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	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Michigan City	802 US Highway 20 East Michigan City, IN 46360

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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 - Some	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** Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to dirty floors, bed rails, baseboards, and ceiling vents, loose trim on floors and baseboards, and marred walls and doors in 2 of 2 units. (The East and [NAME] Units)Findings include:During the Environmental Tour on 8/7/25 at 1:35 p.m., with the Maintenance Director and Housekeeping Director, the following was observed:1. East Unita. The floor and floor mat in room [ROOM NUMBER] were dirty and sticky. The bed rail was visibly dirty with a brown substance stuck on it. One resident resided in the room. These observations were consistent with observations made on 8/4/25 at 11:19 a.m.2. [NAME] Unita. In room [ROOM NUMBER], the trim on the floor in the doorway to the bathroom and the baseboard were coming off. One resident resided in the room.b. In room [ROOM NUMBER], the paint was chipped on the wall by bed 2 and the floor mat was torn along the edge. The floor tile was dirty along baseboard in the entry to the room. Two residents resided in the room.c. In room [ROOM NUMBER], the privacy curtain was stained, and the paint was chipped on the wall by bed 2. The floors in the room and bathroom were discolored. There was an accumulation of dirt along baseboard in entry way of room and the bathroom. Two residents resided in the room. d. In room [ROOM NUMBER], the paint was chipped on the wall behind bed 2. The floor tile was dirty along baseboard in the entry to the room and in the bathroom. Two residents resided in the room.e. In room [ROOM NUMBER], there was debris and food crumbs on the floor around the bed. The resident indicated the room had not been cleaned in two days. One resident resided in the room. f. In room [ROOM NUMBER], the paint was chipped on the wall next to bed 1. The bathroom door was marred. There was an accumulation of dirt along baseboard in the entry to the room and in the bathroom. Two residents resided in the room.g In room [ROOM NUMBER], the wall behind the head of the bed was marred. There was an accumulation of dirt along the baseboard in the entry to the room. One resident resided in the room.h. In room [ROOM NUMBER], the room door and bathroom door were scratched and marred. In the bathroom, there was a rust stain in the sink, a buildup of dirt along the baseboards, and discoloration of the floor tile. Two residents resided in the room.i. In room [ROOM NUMBER], the floor and baseboards were dirty. In the bathroom, the floor was marred and discolored, and the ceiling vent had an accumulation of dust. Two residents resided in the room and used the bathroom. j. In room [ROOM NUMBER], the bathroom ceiling vent had an accumulation of dust. Two residents used the bathroom. During an interview on 8/7/25 at 1:52 p.m., the Maintenance Director and Housekeeping Director indicated all of the above areas were in need of cleaning or repair.3.1-19(f)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had physician's orders for medications and an assessment to self-administer their own medications for 1 of 2 residents reviewed for self-administration of medication. (Resident 20)Finding includes:During random observations on 8/4/25 at 10:05 a.m., 8/4/25 at 3:00 p.m., and 8/5/25 at 2:20 p.m., a container with 4 bottles of re-wetting eye drops was observed on Resident 20's bedside table. One of the bottles had an expiration date of 12/2017. The resident indicated he used the eye drops regularly and independently. The resident's record was reviewed on 8/5/25 at 2:44 p.m. Diagnoses included, but were not limited to, chronic kidney disease, lymphoma, and glaucoma.The 7/5/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had moderate cognitive impairment, and required moderate assistance with activities of daily living (ADLs).The record lacked a self-administration assessment and physician's orders for re-wetting eye drops.During an interview on 8/5/25 at 2:10 p.m., the Assistant Director of Nursing (ADON) indicated a self-administration assessment should be completed and a physician's order obtained for a resident to self-administer medications. A policy titled, Self-Administration of Medications, received as current from the Administrator on 8/7/25 at 3:11 p.m. indicated, . Facility, in conjunction with the interdisciplinary care team, should assess and determine, with respect to each resident, whether self-administration of medications is safe and clinically appropriate, based on the resident's functionality and health condition . Facility should ensure that orders for self-administration list the specific medication(s) the resident may self-administer . Facility should document the self-administration and self-storage of medications in the resident's care plan.3.1-11(a)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to promptly notify the resident's physician of multiple refusals of sliding scale insulin for 1 of 5 residents reviewed for unnecessary medication. (Resident 4)Finding includes:The record for Resident 4 was reviewed on 8/6/25 at 8:56 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, stroke, heart disease, high blood pressure, type 2 diabetes, diabetic neuropathy, heart failure, chronic pain, low back pain, major depressive disorder, chronic migraines, and a history of thrombosis (the formation of a blood clot (thrombus) inside a blood vessel, obstructing the normal flow of blood). The admission Minimum Data Set (MDS) assessment, dated 5/15/25, indicated the resident was cognitively intact for daily decision making and received insulin in the last 7 days. The Care Plan, revised on 5/28/25, indicated the resident refused care such as being repositioned, incontinent checks and changes, and skin assessments. The Care Plan, revised on 5/28/25, indicated the resident has diabetes mellitus. The approaches were to educate regarding medications and importance of compliance. A Physician's Order, dated 5/2/25, indicated Humalog Insulin 100 units/milliliter, inject as per sliding scale: if 0 - 150 = 0 units; 151 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 10 units; 301 - 350 = 12 units; 351 - 400 = 15 units every morning, midday, and evening shifts. The 5/2025 Medication Administration Record (MAR) indicated the resident refused the insulin 7 times for the morning dose, 10 times for the midday dose, and 10 times for the evening dose. The 6/2025 MAR indicated the resident refused the insulin 14 times for the morning dose, 12 times for the midday dose and 13 times for the evening dose. There was no documentation in May or June 2025 to indicate the Physician or Nurse Practitioner (NP) was notified of the repeated refusals of the sliding scale insulin. The first documentation of any type of medication refusals was on 7/2/25 at 4:02 p.m., as the NP note indicated patient's blood sugars have been over 200. Patient is very noncompliant with medications During an interview on 8/7/25 at 3:10 p.m., the Director of Nursing indicated she had reviewed her files and there was no documentation the NP was notified of the resident refusing the insulin, however, there was a care plan that indicated she had refused care. During an interview on 8/8/25 at 11:00 a.m., the Director of Nursing indicated she had spoken to the NP on 8/8/25, and she indicated she was not aware the resident had been refusing her insulin for the months of 5/2025 and 6/2025. The revised and current 6/1/24 Resident Medication Rights policy, provided by the Assistant Director of Nursing on 8/7/25 at 3:27 p.m., indicated the facility should notify the physician/prescriber of a resident's refusal of medications for periods greater than 24 hours. 3.1-5(a)(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a wound vacuum and tubing were kept off the floor and treatments were in place for a non-pressure skin area for 1 of 2 residents reviewed for non-pressure skin areas, a resident was treated for constipation for 1 of 1 resident reviewed for constipation and a resident with a NG tube was assessed and monitored for complications for 1 of 1 resident reviewed for hospice. (Residents 90, 4, and 11)Findings include: 1. During an observation on 8/4/25 at 1:00 p.m., Resident 90 was observed in bed. At that time, the resident had a large bandage over the left knee and it was connected to a wound vacuum (a treatment that used suction to help wounds heal). The wound vacuum and tubing were observed on the floor. The resident was also observed with a pink foam bandage on the back of her right hand with a date of 7/28/25. During an interview with the resident, she indicated she had an allergic reaction while in the hospital from a medication and scratched herself so badly the area became open. On 8/4/25 at 2:28 p.m. RN 1 removed the bandage from the resident's right hand and there was a dark discoloration underneath it. At that time, the wound vacuum and tubing were still observed on the floor. During an interview on 8/4/25 2:30 p.m., RN 1 indicated the area underneath the bandage was a bruise and the initials on the bandage were hers. She did not recall why she had placed the bandage on the back of the resident's right hand, as she was sick and off of work the rest of last week (7/28-8/1/25). The record for Resident 90 was reviewed on 8/5/25 at 2:06 p.m. The resident was admitted to the facility on [DATE], was admitted to the hospital on [DATE] and returned to the facility on 7/28/25. Diagnoses included but were not limited to, history of falling, anxiety, osteoporosis, depression, alcohol abuse, cirrhosis of the liver, infection of the skin, and a laceration of the left knee. The 8/5/25 admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had one surgical wound. A Care Plan, revised on 7/29/25, indicated the resident had a break in skin integrity related to a surgical incision to the left lower extremity. There was no care plan for any non-pressure areas such as bruising or skin tears. The admission Assessment, dated 7/28/25, indicated scattered bruises on both arms and top of hands and right leg. A Skin-Wound Note, dated 7/29/25 at 11:48 a.m., indicated the resident had an open surgical wound to the left knee and a wound vacuum was in place and functioning. There was no documentation or an assessment of any other type of wound or non-pressure area to the back of the right hand. There was no Physician's Order for a foam bandage for the back of the right hand. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order, dated 7/28/25, indicated to cleanse the left knee with wound cleanser, apply wound vacuum using black foam with a layer of Xeroform directly on the wound bed at 125 mmHg (millimeters of mercury), change two times a week. During an interview on 8/7/25 at 10:15 a.m. the Assistant Director of Nursing indicated the wound vacuum and tubing should not have been on the floor and there were no orders for the foam bandage that was on the back of the resident's right hand. 2. During an interview on 8/4/25 at 10:21 a.m., Resident 4 indicated she was constipated all the time and sometimes it was longer than 3 days before she had a bowel movement. The record for Resident 4 was reviewed on 8/6/25 at 8:56 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, stroke, heart disease, high blood pressure, type 2 diabetes, diabetic neuropathy, heart failure, chronic pain, low back pain, major depressive disorder, chronic migraines, and a history of thrombosis (the formation of a blood clot (thrombus) inside a blood vessel, obstructing the normal flow of blood). The admission Minimum Data Set (MDS) assessment, dated 5/15/25, indicated the resident was cognitively intact for daily decision making and was dependent on staff for toileting. The resident was always incontinent of bowel and was not on any bowel program. The resident received insulin in the last 7 days and also received an opioid medication. A Care Plan, revised on 5/28/25, indicated the resident was at risk for constipation related to decreased mobility and use/side effects of medication. The approaches were to record bowel movement pattern each day. The bowel and bladder elimination record in the CNA task section indicated the resident was coded as having no bowel movement on 7/8, 7/9, 7/11, 7/12, 7/13, 7/14, 7/19, 7/20, 7/29, 7/30, 7/31, 8/1, 8/2, and 8/3/25. There was no documentation and the days were blank on 8/4 and 8/5/25. Physician's Orders, dated 5/2/25, indicated Oxycodone (a narcotic medication) 5-325 milligrams (mg), give one tablet by mouth every four hours as needed for pain and Docusate Sodium (a stool softener medication) 100 mg, give one capsule by mouth as needed daily for constipation. A Physician's Order, dated 6/26/25, indicated Miralax (an over the counter laxative medication) packet 17 grams, give one packet by mouth daily as needed for constipation. The 5/2025 Medication Administration Record (MAR) indicated the resident received the Oxycodone medication 58 times, the Docusate medication two times and the Miralax one time. The 6/2025 MAR indicated the resident received the Oxycodone 49 times and did not receive the Docusate or Miralax. The 7/2025 MAR indicated the resident received the Oxycodone 66 times and did not receive the Docusate or Miralax. The 8/2025 MAR indicated the resident received the Oxycodone 15 times and did not receive the the Docusate or Miralax. During an interview on 8/7/25 at 11:33 a.m., the Director of Nursing (DON) indicated they were made (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aware the resident had no bowel movement and when a staff member went down to ask the resident, she said she had one on the 7/30/25. They were made aware she had not had one in the last few days and was told that nursing staff gave her a prn laxative, however, nothing was documented on the MAR, nor was the bowel movement documented. The current and revised Bowel Protocol policy, provided by the DON on 8/7/25 at 2:05 p.m., indicated nursing staff will record in the electronic health record each time a resident has a bowel movement. The facility in coordination with the resident's attending practitioner will implement standing orders to address a lack of bowel movement. 3. During a random observation on 8/6/25 at 9:03 a.m., Resident 11 was observed lying in bed. A nasogastric (NG) tube (a tube inserted through the nose into the stomach) was observed connected to a suction machine. There were dark brown flecks in the tubing. The suction canister was empty. The record for Resident 11 was reviewed on 8/6/25 at 9:54 a.m. Diagnoses included, but were not limited to, cancer of the rectum and liver, colostomy, and intestinal obstruction. The 7/21/25 admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and required substantial assistance with ADLs and transfers. A 7/15/25 Physician's Order indicated the resident was to have the NG tube to low intermittent suction, and to have nothing by mouth. The record indicated an NG output of 10 milliliters on 7/21/25. All other documented outputs were zero. The record lacked documentation of verification of correct NG tube placement, correct functioning equipment, and inspection of the skin for medical device-related pressure injury. The record lacked a care plan for the resident having an NG tube. During an interview on 8/6/25 at 11:16 a.m., RN 2 indicated the nurses' only responsibility related to the NG tube was to document the output amount, but there had not been any. Hospice managed the NG tube. During an interview on 8/7/25 at 10:30 a.m., the Director of Nursing (DON) indicated the NG tube was managed by hospice, who came three times a week. During an interview on 8/8/25 at 11:05 a.m., the DON indicated although hospice was supposed to manage the NG tube, the nursing care for the resident having the NG should still be in place. A policy titled, Nasogastric or orogastric tube monitoring, received as current from the DON on 8/7/25 at 12:30 p.m. indicated, . Effective NG or OG tube care requires meticulous monitoring of the patient and the equipment. Patient monitoring involves assessing GI function, including the volume and appearance of NG or OG tube drainage (if applicable); equipment monitoring involves verifying correct tube placement and function . Inspect the skin around the NG or OG tube by lifting and repositioning the tube gently at least daily to prevent medical device-related pressure injury . confirm accurate NG or OG tube placement regularly . using at least two bedside techniques . Special Considerations. NG or OG tubes can become clogged or incorrectly positioned . If no drainage appears in the tube, check the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suction equipment for proper function . 3.1-37(a)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident received routine eye care and was seen by an Optometrist for 1 of 1 resident reviewed for vision. (Resident 4) Finding includes:During an interview on 8/4/25 at 10:14 a.m., Resident 4 indicated she needed to see the eye doctor to have another cataract surgery. She had the first one in 1/2025. The record for Resident 4 was reviewed on 8/6/25 at 8:56 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, stroke, heart disease, high blood pressure, type 2 diabetes, diabetic neuropathy, heart failure, chronic pain, low back pain, major depressive disorder, chronic migraines, and a history of thrombosis (the formation of a blood clot (thrombus) inside a blood vessel, obstructing the normal flow of blood). The admission Minimum Data Set (MDS) assessment, dated 5/15/25, indicated the resident was cognitively intact for daily decision making and had adequate vision with no corrective lens. A signed consent, dated 5/5/25, indicated the resident wished to have optometry care at the facility. During an interview on 8/6/25 at 11:00 a.m., the Social Service Director (SSD) indicated she was unaware the resident needed to see the eye doctor. During an interview on 8/6/25 at 12:54 p.m., the SSD indicated the optometrist was last at the facility on 6/12/25 and the resident was not seen. The list was finalized on 6/5/25, however, she was unaware the resident wanted to be seen. She indicated she did not follow up with the resident after the consent had been signed. 3.1-39(a)(1)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents received foot care and routine visits with the podiatrist for 1 of 1 resident reviewed for foot care. (Resident 4) Finding includes:During an interview on 8/4/25 at 10:16 a.m., Resident 4 indicated she had told staff she wanted to see a podiatrist at the time of admission. The record for Resident 4 was reviewed on 8/6/25 at 8:56 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, stroke, heart disease, high blood pressure, type 2 diabetes, diabetic neuropathy, heart failure, chronic pain, low back pain, major depressive disorder, chronic migraines, and a history of thrombosis (the formation of a blood clot (thrombus) inside a blood vessel, obstructing the normal flow of blood). The admission Minimum Data Set (MDS) assessment, dated 5/15/25, indicated the resident was cognitively intact for daily decision making. A signed consent, dated 5/5/25, indicated the resident wished to have podiatry care at the facility. During an interview on 8/6/25 at 11:00 a.m., the Social Service Director (SSD) indicated the resident was on the list to be seen by the Podiatrist for 8/7/25. She had not seen one since admission. Their normal Podiatrist was out of the country and they were using a different one and were having some issues with them, as they were behind on the visits. During an interview on 8/6/25 at 12:54 p.m., the SSD indicated the last time a Podiatrist was in the facility was on 5/29/25 and the resident was not seen. 3.1-47(a)(7)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on record review and interview, the facility failed to ensure psychological services were offered for a resident exhibiting signs and symptoms of depression for 1 of 1 resident reviewed for mood and behavior. (Resident 5)Finding includes:During an interview on 8/4/25 at 9:53 a.m., Resident 5 indicated she had some feelings of depression. She indicated she did not receive an antidepressant but she would like to talk to somebody. The resident indicated that she told the Speech Therapist but she didn't know if the therapist told nursing. The record for Resident 5 was reviewed on 8/7/25 at 3:42 p.m. Diagnoses included, but were not limited to, displaced comminuted fracture of the shaft of the left femur and depression. The admission Minimum Data Set (MDS) assessment, dated 3/31/25, indicated the resident was cognitively intact and had no mood issues. The Quarterly MDS assessment, dated 6/30/25, indicated the resident had moderate cognitive impairment and she had little interest or pleasure in doing things and she was also feeling down, depressed, or hopeless 2-6 days during the assessment reference period. The resident had no behaviors and was not receiving an antidepressant. A Care Plan, dated 4/29/25 and reviewed on 7/22/25, indicated the resident had depression and was not currently taking medications. Interventions included, but were not limited to, observe for and report as needed (PRN) any signs and symptoms of depression including, hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statements, repetitive anxious or health-related complaints, and tearfulness. A Staff Assessment of Resident Mood, dated 6/30/25, indicated the resident had little interest or pleasure in doing things and she was also feeling down, depressed, or hopeless during the last 2-6 days. There was no Social Service progress note addressing the resident's mood on or after 6/30/25. The August 2025 Physician's Order Summary (POS), indicated the resident was not receiving an antidepressant and there was no order for psychological services. During an interview on 8/8/25 at 10:30 a.m., the Social Service Director indicated when new onset mood issues were identified she would notify nursing, the Nurse Practitioner, or the physician and she would ask the resident if they would like psych services. The Social Service Director indicated she would get an order for psych services for the resident. 3.1-34(a)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and interview, the facility failed to store over the counter medications and insulin securely in a locked medication cart for 2 of 2 residents reviewed for medication storage. (Residents 42 and 3)Findings include:1. During random observations on 8/4/25 at 10:00 a.m. and 1:13 p.m. and on 8/5/25 at 9:09 a.m. and 1:55 p.m., Resident 42 was observed in her room and in bed. At those times there was an unopened multi-use vial of Insulin on the resident's nightstand with a label of the resident's name on it. On 8/5/25 at 3:41 p.m., the Nurse Trainer entered the resident's room and observed the insulin vial on top of the nightstand and asked the resident if she could remove it. The record for Resident 42 was reviewed on 8/5/25 at 1:57 p.m. Diagnoses included, but were not limited to, acute respiratory failure, heart disease, heart failure, dementia without behaviors, and high blood pressure. The 6/20/25 Annual Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact for daily decision making and needed substantial assistance with activities of daily living. There was no care plan the resident could store medications in her room. There was no physician's order for any type of insulin. During an interview on 8/5/25 at 3:55 p.m., the Nurse Trainer indicated the vial of insulin should not have been on the nightstand. During an interview on 8/5/25 at 3:56 p.m., the Director of Nursing indicated the resident had never received insulin during her stay and she had no idea where it could have come from. 2. During random observations on 8/4/25 10:00 a.m. and 1:10 p.m., there was a bottle of over the counter castor oil on Resident 3's over bed table. The resident was not in her room during those times and was at dialysis. During an interview on 8/5/2025 at 10:27 a.m., the resident indicated she used the castor oil for her hair, and did not consume it. During an observation on 8/5/25 at 1:50 p.m., the castor oil was still observed on the over bed table. On 8/5/25 at 3:41 p.m., the Nurse Trainer entered the resident's room and observed the bottle of castor oil on the resident's over bed table. She asked the resident if she could take it and write some information down and then she would bring it back. The resident indicated at that time, she used the oil for her hair only. The record for Resident 3 was reviewed on 8/6/25 at 2:25 p.m. Diagnoses included, but were not limited to, stroke, heart disease, end stage renal disease, high blood pressure, heart failure, major depressive disorder, and dependence on renal dialysis. The Modification of the 6/18/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. There was no care plan the resident could store over the counter medications in her room. During an interview on 8/5/25 at 3:55 p.m., the Nurse Trainer indicated the castor oil should be in a lock box or kept secured in the room. The current and revised 8/7/23 Storage and Expiration Dating of Medications and Biologicals policy, provided by the Director of Nursing on 8/7/25 at 11:33 a.m., indicated the facility should ensure that all medications and biologicals, including treatment items, were securely stored in a locked cabinet or medication cart. 3.1-25(j)

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	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Michigan City	802 US Highway 20 East Michigan City, IN 46360

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to a lack of documentation of blisters for 1 of 1 resident reviewed for non-pressure skin conditions (Resident 67), and inaccurate meal consumption documentation for a resident who was NPO (nothing by mouth) for 1 of 1 resident reviewed for hospice. (Resident 11)Findings include: 1. During a random observation on 8/4/25 at 8:41 a.m., Resident 67's legs were wrapped in gauze. At that time, the resident indicated there used to be blisters on her legs, but she was not sure if they were still there.During an observation of treatment on 8/07/25 at 1:11 p.m., a small, dark, circular discoloration was observed to the resident's left shin. At that time, the Assistant Director of Nursing (ADON) indicated it used to be a blister. She indicated the resident used to have multiple small blisters to both legs, but they had healed. The record for Resident 67 was reviewed on 8/5/25 at 3:07 p.m. Diagnoses included, but were not limited to, legal blindness and edema (swelling).The 5/20/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making, and required substantial assistance with ADLs and transfers. A 7/30/25 Physician's Order indicated: cleanse both legs with wound wash, apply Xeroform (a non-adherent dressing), ABDs (a gauze pad), secure with Kerlix (a rolled gauze), one time a day for blisters. The record lacked documentation of the resident having blisters on her legs.During an interview on 8/7/25 at 2:10 p.m., the ADON indicated she had been monitoring the resident's blisters to her legs, but had not been documenting it. 2. During a random observation on 8/6/25 9:03 a.m., Resident 11 was observed lying in bed. A nasogastric (NG) tube (a tube inserted through the nose into the stomach) was observed, connected to a suction machine. The record for Resident 11 was reviewed on 8/6/25 at 9:54 a.m. Diagnoses included, but were not limited to, cancer of the rectum and liver, colostomy, and intestinal obstruction.The 7/21/25 admission MDS assessment indicated the resident was cognitively intact for daily decision making and required substantial assistance with ADLs and transfers.A 7/15/25 Physician's Order indicated the resident was to have the NG tube to low intermittent suction, and to have nothing by mouth.A Care Plan, reviewed 8/5/25, indicated the resident status was NPO (nothing by mouth) except ice chips and small sips of water.In the Tasks section of the record, resident meal intakes were recorded on 7/17/25, 7/21/25, 7/22/25, 7/25/25, 7/27/25, 7/28/25, 7/29/25, 8/1/25, 8/2/25, and 8/3/25. During an interview on 8/7/25 at 10:30 a.m., the Director of Nursing (DON) indicated the resident had not eaten since prior to admission. Meal consumptions should not be documented because the resident did not eat. 3.1-50(a)

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	155344	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Michigan City	802 US Highway 20 East Michigan City, IN 46360

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review and interview, the facility failed to ensure infection control practices were in place and implemented related to enhanced barrier precautions (EBP) not followed while assisting a resident who had a Foley catheter to the bathroom and emptying an indwelling Foley catheter during random infection control observations. (Residents 5 and 56)Findings include:1. During a random observation on 8/5/25 at 9:15 a.m., Occupational Therapy Assistant (OTA) 1 was assisting Resident 5 with a toilet transfer. The OTA was wearing gloves but was not wearing an isolation gown. The resident had an indwelling Foley catheter. During a random observation on 8/6/25 at 1:11 p.m., CNA 1 was draining the resident's Foley catheter leg bag. The CNA had donned a pair of gloves, but she was not wearing an isolation gown. The record for Resident 5 was reviewed on 8/7/25 at 3:42 p.m. Diagnoses included, but were not limited to, displaced comminuted fracture of the shaft of the left femur and neuromuscular dysfunction of the bladder (nerve damage that impaired the bladder's ability to store and release urine properly). The Quarterly Minimum Data Set (MDS) assessment, dated 6/30/25, indicated the resident had moderate cognitive impairment and an indwelling catheter. A Care Plan, dated 3/31/25 and reviewed on 7/22/25, indicated the resident had an indwelling Foley catheter related to neurogenic bladder and was at risk for infection. Interventions included, but were not limited to, enhanced barrier precautions (EBP).Enhanced barrier precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with multidrug-resistant organisms (MDRO) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).A Physician's Order, dated 7/16/25, indicated the resident had an 18 French 30 cubic centimeter (cc's) indwelling Foley catheter. During an interview on 8/7/25 at 3:10 p.m., the Director of Nursing indicated the CNA had just recently finished her training and she should have worn a gown while emptying the Foley catheter bag and therapy staff should have worn a gown when assisting the resident in the bathroom. 2. During a random observation on 8/6/25 at 1:11 p.m., CNA 1 was observed from the doorway of Resident 56's room emptying her Foley catheter drainage bag which was attached to her leg. The CNA had donned a pair of gloves but was not wearing an isolation gown. A sign on the door to the resident's room indicated she required enhanced barrier precautions (EBP). Enhanced barrier precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with multidrug-resistant organisms (MDRO) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).During an interview on 8/7/25 at 3:10 p.m., the Director of Nursing indicated the CNA had just recently finished her training and she should have worn a gown while emptying the Foley catheter bag. 3.1-18(b)