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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00414907, IN00415789, and IN00416649. Complaint IN00414907 - Federal/State deficiencies related to the allegations are cited at F759 and F842. Complaint IN00415789 - Federal/State deficiencies related to the allegations are cited at F759 and F921 . Complaint IN00416649 - Federal/State deficiencies related to the allegations are cited at F759. Unrelated deficiencies are cited. Survey dates: September 11 & 12, 2023 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Census Bed Type: SNF/NF: 101 Total: 101 Census Payor Type: Medicare: 7 Medicaid: 76 Other: 18 Total: 101 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/15/23.	F 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. Facility respectfully requests paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason E Eastlund	Executive Director	09/29/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, record review, and interview the facility failed to care for a PICC (peripherally inserted central catheter) line in accordance with professional standards of practice, related to not obtaining line flush orders, lack of aseptic technique with care of the line, and dressing changes, for 1 of 3 residents reviewed for PICC line care. (Resident F) Finding includes: During an observation on 9/11/23 at 5 a.m., Resident F was in bed with his eyes opened. There was a PICC line located in the left upper arm with a dressing dated 9/5/23. There was a bag of 0.9% normal saline with a 3.375 gram bottle of piperacillin (antibiotic) hanging on the normal saline bag. There was liquid approximately in a quarter of the bottle that the piperacillin medication was diluted with. The normal saline bag was empty and the IV (intravenous) infusion pump was beeping and with a warning there was air in the line. LPN 4 entered the room and indicated she had ensured all the medication was in the IV bag before starting the medication and squeezed the bottle into the IV bag to allowed the rest of the piperacillin to be infused. She then removed the IV line from the PICC and primed the IV line with the	F 0694	**F 694** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1 Resident F was not harmed by the alleged deficient practice. Resident F was assessed by licensed nurse and was not noted with any adverse effects related to the alleged deficient practice. The physician was immediately notified and new orders were received for PICC line dressing change, and a PICC line flush. Care of the PICC line was completed immediately, by a licensed nurse utilizing aseptic technique, per facility policy.	09/29/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	fluid and then flushed the PICC with 5 cc's (cubic centimeters) of normal saline, then placed the line back into the PICC hub (port). Alcohol swabs were not used for the insertion and removal of the flush or the IV line into the PICC hub. During an interview after the observation , LPN 4 indicated she was unsure if she needed to use an alcohol swab on the hub of the PICC line. Resident F's record was reviewed on 9/12/23 at 11:44 a.m. The diagnoses included, but were not limited to, stroke and diabetes mellitus. A Quarterly Minimum Data Set assessment, dated 7/20/23, indicated a moderately impaired cognitive status and no infections. A Care Plan, dated 9/7/23, indicated a PICC line in the left upper arm. The interventions included, to flush the PICC line as ordered by the Physician and the dressing on the PICC was to be changed 24 hours after the PICC line was inserted and then weekly. The flush was to be of 10 cc's of normal saline and followed by 5 cc of heparin (blood thinner). The PICC insertion site was to be visually inspected each shift for bleeding, redness, swelling, pain, or drainage. A Physician's Order, dated 9/5/23, indicated a PICC line was to be inserted. There were no orders for flushing the PICC line or for the dressing changes. The Pharmacy IV form indicated the PICC was inserted on 9/5/23 at 7 p.m. The PICC insertion site was monitored per the		2 All residents with a PICC line have the potential to be affected by the same alleged deficient practice. All residents with a PICC line have been audited to ensure that they have orders to have their PICC line dressing changed to match facility policy and flush orders in place. All PICC insertion sites have received site care facility policy. Audit completed prior to date of compliance. 3 DON/Designee has educated all licensed nurses on the Peripherally Inserted Central Line policy with an emphasis on dressing changes and PICC line insertion site care. All education completed prior to date of compliance 4 DON/Designee will audit all residents with a PICC Line to ensure they have orders to change the PICC Line dressing per facility policy, to ensure that flush orders are present and to ensure that the PICC insertion site care is completed per facility policy. This audit will occur 3 X per week for 12 weeks. DON/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	Nurses' Progress Notes on 9/6/23 at 10:44 a.m. and 9:02 p.m., 9/7/23 at 12:37 p.m., 9/8/23 at 12:40 p.m. and 9:02 p.m., 9/9/23 at 12:54 p.m. and 3:57 p.m., 9/10/23 at 12 a.m. and 11:29 a.m., 9/11/23 at 10:10 a.m. and 9:14 p.m. The insertion site had not been monitored every shift per the care plan interventions. A facility policy, dated 12/2014 and titled, "Intermittent Infusion", received from the Administrator as current, indicated the venous access devices were to be flushed as ordered. The needless connector (hub) was to be vigorously cleansed with alcohol and allowed to air dry prior to and after flushing and prior to attaching the IV line. A facility policy, dated 2/2009, titled, "Central Venous Catheter", received from the DON as current, indicated a Physician's Order was to be obtained for dressing changes. 3.1-47(a)(2)		achieved.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 5 residents reviewed during 5 medication pass observations. 3 errors in medications were observed during 33 opportunities for errors in medication administration. This resulted in a medication error	F 0759	**F 759** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of	09/29/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	rate of 9.09%. (Residents L & M) Findings include: 1) During a morning Medication Pass Observation on 9/11/23 at 7:24 a.m., RN 2 prepared Resident L's medication for administration, which included vitamin D3 (cholecalciferol) (supplement), 1000 IU (international units), 1 tablet. The label on the vitamin D3 indicated 2000 IU (two tablets) were to be administered. RN 2 indicated there were nine pills in the medication cup to be administered (count should have been 10 if the second vitamin D3 had been included), and then proceeded to administer the medications to the resident. Resident L's record was reviewed on 9/11/23 at 10:22 a.m. The diagnoses included, but were not limited to, fractured right femur and hypertension. A Physician's Order, dated 11/10/22, indicated 2000 IU (two tablets) of the vitamin D3 was to be administered every morning. 2) During a Medication Pass Observation on 9/11/23 at 8:04 a.m., RN 3 prepared Resident M's medication for administration, which included gabapentin (nerve pain) 100 mg (milligrams), two capsules, and metoclopramide (antiemetic) 5 mg, one tablet. There were 14 pills total which should have been administered. RN 3 placed only one gabapentin in the medication cup for the administration. The label on the medication indicated 200 mg of gabapentin was to be administered.		correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1 Resident L and Resident M were not harmed by the alleged deficient practice. Resident L and Resident M were assessed, by a licensed nurse, and were not noted with any adverse effects related to the alleged deficient practice. The physician and responsible party were immediately notified of the medication administration error. 2 All residents who take oral medications have the potential to be affected by same alleged deficient practice. All residents that receive oral medications that require multi-tablet doses have been audited by direct observation, to ensure the correct dose administration, prior to date of compliance. 3 DON/Designee has educated all licensed nurses on the medication administration policy with an emphasis on the five rights of administration. All Licensed Nurses were required to pass a dosage test after education was provided. All education and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	After all the medications for the administration were placed in the medication cup, RN 3 returned the medication cards to the drawer on the cart. There was a small white pill lying on top of the cart next to the plastic medication cart. RN 3 placed the little white pill in the biohazard container. RN 3 then indicated she had counted the cards when she placed them in the cart and there were 13 pills in the medication cup and was ready to administer the medications to Resident M. She then counted the actual pills in the medication cup, when asked to do so, and indicated there were 12 medications in the cup. She then checked each medication with the medication card and indicated the little white pill that was discarded was the metoclopramide and replaced the pill in the medication cup. She then entered the resident's room for the medication administration. Resident M indicated she had pain everywhere and rated it at a 7 out of 10 and had not wanted to take her medication RN 3 had brought into the room. RN 3 indicated she would get her a, "Tylenol" for the pain. She exited the room with the medication cup of medications and added an acetaminophen 500 mg, 1 tablet to the medication cup. When asked about the gabapentin, RN 3 removed the medication card from the drawer and indicated after reading the label, the resident should get two tablets, not one and placed another tablet in the medication cup. She then attempted to administer the medications again and the resident accepted the medications.		testing completed prior to date of compliance. 4 DON/Designee will observe two staff nurses 3 x per week, perform their medication pass to ensure that medication is being administered as ordered by the physician. DON/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	Resident M's record was reviewed on 9/11/23 at 10:38 a.m. The diagnoses included, but were not limited to diabetes mellitus. A Physician's Order, dated 5/17/23, indicated gabapentin 100 mg, give 200 mg by mouth three times a day. A Medication Administration policy, received as current from the Director of Nursing on 9/11/23 at 1:29 p.m., indicated, medications were to be administered as prescribed by the Provider. This Federal tag relates to Complaints IN00414907, IN00415789, and IN00416649. 3.1-25(b)(9) 3.1-48(c)(1)			
F 0800 SS=D Bldg. 00	483.60 Provided Diet Meets Needs of Each Resident §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Based on observation, record review, and interview, the facility failed to provide residents with diets as care-planned, ordered, and per preferences, for 3 of 3 residents reviewed for nutritional services. (Residents J, K, and L) Findings include: 1. During an interview on 9/11/23 at 12:29 p.m., Resident J indicated she did not like what food was being served. She did not receive what she was supposed to get for her meals and her food	F 0800	**F 800** **Diet meets needs** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of	09/29/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	was cold when she ate her meals in her room. During an observation of the breakfast meal on 9/12/23 at 8:42 a.m., she received a cheese omelet, bacon and a cinnamon roll. There was a carton of 2% milk and a glass of apple juice on the tray also. The Dietary Card on the tray indicated a Regular diet and was to receive a baked cheese omelet, two slices of bacon, 6 ounces of fortified hot cereal of choice, a English muffin, one packet of jelly, one packet of margarine, and eight ounces of whole milk. There was no fortified hot cereal, English muffin, jelly, margarine, or whole milk on the breakfast tray. The resident indicated at the time of the observation that the 2% milk was "ok" with her and acknowledged she had not received the cereal, English muffin, jelly and margarine. During an interview on 9/12/23 at 9:08 a.m., the Unit Manager acknowledged the missing items on the breakfast tray. The resident indicated she was full and no longer wanted the cereal. Resident J's record was reviewed on 9/12/23 at 8:26 a.m. The diagnoses included, but were not limited to, pulmonary hypertension and adult failure to thrive. A Quarterly Minimum Data Set (MDS) assessment, dated 8/15/23, indicated an intact cognition, no behaviors, supervision with eating, a weight of 162 pounds, and no significant weight gain or loss. A Care Plan, dated 10/10/22 and revised on 1/2/23, indicated an altered nutritional status. The interventions included, fortified foods at breakfast		federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1 Resident J, K and L were not harmed by the alleged deficient practice. Resident's had diet preferences updated and diet orders reviewed for accuracy. The physician and the responsible party for each resident were notified of the diet not being served as ordered and preferred. 2 All residents with an oral diet order have the potential to be affected. Resident diet orders were audited by observation of a meal pass to ensure the resident was served diet according to preference and as ordered, prior to date of compliance. 3 ED/Designee provided education to all dietary staff to ensure meals are served according to resident preference and as ordered per the physician, per the printed meal tickets on each tray, prior to date of compliance. 4 ED/Designee will audit 10 meal trays per week related to meal ticket matching what is served along with 3 test trays per week to ensure appropriate temperatures. Audits will be conducted for 12 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	and whole milk was to be served at all meals. A Physician's Order, dated 9/7/23, indicated a regular diet. A Dietary Progress Note, dated 9/9/23, indicated a weight increase of over 10% in the past 180 days. The current interventions would be continued. 2. During an observation on 9/12/23 at 9:09 a.m., Resident K was in bed and feeding himself stiff/set cream of wheat. There was no milk on the breakfast tray. He had already consumed the baked cheese omelet and stated he had received one omelet. He stated he preferred oatmeal as his hot cereal. He had not received milk, the English muffin, margarine, or jelly. The Dietary Card on the tray indicated he was on a regular diet, was to receive double proteins, and the breakfast tray was to have two baked cheese omelets, two slices of bacon, six ounces of oatmeal, one English muffin, one packet of jelly, one packet of margarine, and eight ounces of milk. Resident K's record was reviewed on 9/12/23 at 1:25 p.m. The diagnoses included, but were not limited to, stroke. A Quarterly MDS assessment, dated 8/5/23, indicated an intact cognation, was able to feed himself, a weight of 127 pounds, and no significant weight loss or gain. A Care Plan, dated 5/1/23, indicated a potential for an altered nutrition status. The interventions included the diet would be served as ordered by the Physician. A Physician's Order, dated 6/4/23, indicated a		ED/designee will report all negative findings to monthly QAPI meeting for a period of 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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

regular, no added salt diet was to be received.

A Dietary Nutritional Assessment, dated 8/13/23, indicated he was underweight for advanced age and to avoid an unintentional weight loss.

3. During an interview on 9/12/23 at 9:03 a.m., Resident L, indicated he had not received two baked cheese omelets, the English muffin, jelly, nor margarine. He had received a dry piece of toast instead and there was no margarine to put on the toast. He indicated he was hungry, so he ate the one piece of toast.

The Dietary Card on the breakfast tray indicated he was on a regular diet with double protein portions. He was to have received two baked cheese omelets, four slices of bacon, one serving of the cereal, one English muffin, one packet of jelly, and one packet of margarine.

Resident L's record was reviewed on 9/12/23 at 1:53 p.m. The diagnoses included, but were not limited to, right femur fracture.

A Quarterly MDS assessment, dated 8/28/23, indicated an intact cognitive status, had no behaviors, fed himself, was 285 pounds, and had no significant weight loss or gain.

A Care Plan, dated 12/30/22, indicated a risk for altered skin integrity. The interventions include, the diet would be served as ordered by the Physician.

A Care Plan, revised on 3/6/23, indicated a potential for an altered nutritional status. The interventions included the resident's preferences would be identified and meals would be provided as ordered by the Physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	A Physician's Order, dated 6/1/22, indicated a regular diet with double protein was to be served. 3.1-20(a)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.			
	Based on observation, interview, and record review, the facility failed to ensure a meal was served at an appetizing temperature related to the temperature of the hot foods served for a breakfast meal for 1 of 3 Units (East), which has the potential to affect the 30 residents who resided on the Unit. Finding includes: During interviews with Resident E on 9/11/23 at 4:31 a.m., Resident J on 9/11/23 at 12:29 p.m., and Resident L on 9/11/23 at 2:55 p.m., they indicated the meals were often cold when served. During an observation on 9/12/23 at 8:36 a.m., the breakfast trays arrived on the East Unit. The staff began passing the meal out to the residents in their rooms.	F 0804	**F 804** **Nutritional value/appeal** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1 Residents E, L and K were not harmed by the alleged deficient practice. Each resident was immediately offered a	09/29/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	All breakfast meals were delivered to the residents at 8:55 a.m. and there were two trays left in the cart, which were identified as one of the trays, the resident was not in the facility and the other tray, the resident refused the meal. The aide had taken the tray into Resident N, and immediately walked back out of the room with the plate covered when the resident indicated he had not wanted the tray. She then placed the tray in the cart with the other trays. The tray for Resident N was then tested for the temperature of the food. The baked cheese omelette was 83.8 degrees and tasted cold, the cinnamon roll was 110.1 degrees and tasted tepid, the hot cereal was 110.1 degrees. The Administrator observed the testing of the food temperatures and was aware of the cool temperatures. He indicated the plates should have been sitting in a thermal plate cover. An interview on 9/12/23 at 9:30 a.m., Resident L indicated his cheese omelette and toast was cold when served. A facility policy, dated 9/2017, titled, "Food:Quality and Palatability", received from the Administrator as current, indicated the food would be served at the appropriate temperature as determined by the type of food to ensure resident's satisfaction. 3.1-21(a)(2)		replacement tray of food served at an appropriate temperature. 2 All residents served a meal tray have the potential to be affected by the alleged deficient practice. A test tray for 6 different meals has been audited to ensure the meal is served at the appropriate serving temperature, prior to date of compliance. 3 ED/Designee provided education to dietary department per facility policy with an emphasis on appropriate food temperatures to be served, prior to date of compliance. 4 ED/Designee will audit 3 test trays per week to ensure appropriate temperatures and palatability. Audits will be conducted for 12 weeks. ED/designee will report all negative findings to monthly QAPI meeting for a period of 6 months.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on record review and interview, the facility failed to ensure a resident's record was accurately documented, related to documenting a medication was administered when the medication had been omitted, for 1 of 3 residents reviewed for documentation of medications. (Resident D) Finding includes: Resident D's record was reviewed on 9/11/23 at 9:33 a.m. Diagnoses included, but were not limited to, stroke, hypertension (high blood pressure), seizure disorder, anxiety, and asthma.	F 0842	**F842** **Resident Records- Identifiable Information** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law.	09/29/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	A Physician's Order, dated 8/23/23, indicated to administer Nystatin Mouth/Throat Suspension 100000 UNIT/ML (antifungal), 5 milliliters was to be administered by mouth four times a day for a fungal infection. The Medication Administration Record, dated 9/2023, indicated the Nystatin was signed out as administered by QMA 1 on 9/1/23 at 9 a.m. An interview with QMA 1 on 9/12/23 at 9:00 a.m., indicated she had not administered the Nystatin to the resident on 9/1/23. An interview with the Director of Nursing on 9/12/23 at 12:19 p.m., indicated the QMA shouldn't have documented a medication had been administered if it had not been given. This Federal tag relates to Complaint IN00414907. 3.1-50(a)(2)		**The facility cordially requests paper compliance regarding alleged deficient practices.** 1 Resident D was not harmed by the alleged deficient practice. Resident D no longer resides at the facility. 2 All residents, who take medication have the potential to be affected. DON/Designee completed a 100% resident medication record review to ensure that all medications that were signed out as administered were given as ordered. The audit was completed prior to date of compliance. 3 DON/Designee has educated all licensed nurses and Qualified Medication Aides on the clinical documentation standards policy with emphasis on truthful and accurate documentation, ensuring resident accuracy related to medication administration documentation, prior to date of compliance. 4 DON/Designee will observe two staff nurses 3 x per week, perform their medication pass to ensure accurate documentation of medication administration DON/designee will perform the medication observation 3 X per week for 12 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
			DON/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	necessary. Based on observation and interview, the facility failed to ensure an employee completed proper hand hygiene after coughing and blowing their nose for 1 staff member on 1 of 3 units (East Unit) during a random observation for infection control, which had the potential to affect the 30 residents on the unit. (LPN 5) Finding includes: During an observation on 9/12/23 at 8:39 a.m., LPN 5 was assisting with the passing of the breakfast trays to the residents. She was standing in the hallway near the tray cart and covered her mouth with her hand and coughed. She then removed a tissue from her pocket and blew her nose. She placed the tissue back into her pocked and then went to the food cart to obtain a tray without performing hand hygiene. LPN 5 was asked to complete hand hygiene. The Unit Manager was informed without further information provided. 3.1-18(b)(1)	F 0880	**F880- Infection Prevention and Control** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1 No residents were affected by the alleged deficient practice. 2 All residents on the East unit have the potential to be affected by the alleged deficient practice. All residents on the East unit have been assessed for signs and symptoms of infection with no negative findings. This audit was completed by the diet of compliance. 3 DON/Designee provided education 1:1 with LPN #5 as well as all staff on the hand hygiene policy with an emphasis on proper procedure prior to date of compliance.	09/29/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
			4 DON/Designee will observe a meal tray pass to ensure appropriate hand hygiene completed 3 x per week x 12 weeks. DON/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
F 0921 SS=C Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interviews, the facility failed to ensure the facility was a sanitary and comfortable environment for the residents, related to cigarette smoking where the residents are taken in and out of the building by the Ambulance (Ambulance Bay), which had the potential to affect any of the 101 residents who reside in the facility if they are transferred by Ambulance. Finding includes: An observation of the Ambulance Bay on 9/11/23 at 2:25 p.m., indicated a No Smoking Sign located directly outside of the entry door. The area had a very strong smell of cigarette smoke and there were more than 10 smoked cigarette butts located on the ground inside the bay. The Administrator indicated on 9/11/23 at 2:30 p.m. that the Ambulance Bay was a no-smoking	F 0921	**F 921** **Safe/Sanitary Environment** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1 Maintenance Department immediately swept the ambulance bay. 2 ED/Designee reviewed all	09/29/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	area. This Federal tag relates to Complaint IN00415789. 3.1-19(f)		other exit doors to ensure there were no cigarette butts present, prior to date of compliance. 3 ED/Designee completed education regarding smoking in the ambulance bay to all staff, prior to date of compliance. 4 ED/Designee to monitor ambulance bay 3 X per week X 12 weeks to ensure there are no cigarette butts present on the ground. ED/designee will report all negative findings to monthly QAPI meeting for a period of 6 months.	