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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) D			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155218	B. W	ING		11/18/	/2021
				CTREET	ADDRESS SITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
CDEATI	ALCO LICALTUCA	DE CENTED			REAT LAKES DR		
GREAT L	AKES HEALTHCA	ARE CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
		he Investigation of Complaints	F 00	000	The Plan of Correction is the		
	IN00364158, IN00	365837, IN00365839,			center's credible allegation of		
	IN00365910 and II	N00366713.			compliance. Preparation and		
					execution of this plan of		
	-	4158 - Substantiated.			correction does not constitute		
		iencies related to the			admission or agreement by the		
	allegations are cited	d at F695 and F880.			provider of the truth of the fact		
					alleged or conclusions set fort	h in	
	-	5837 - Substantiated. No			the statement of deficiencies.		
	deficiencies related	I to the allegations are cited.			This plan of correction is		
					prepared and/or executed sole	ely	
	-	5839 - Substantiated. No			because it is required by the		
	deficiencies related	I to the allegations are cited.			provisions of the federal and s	tate	
					law. The facility respectfully		
	-	5910- Substantiated. No			requests a desk review for this	3	
	deficiencies related	I to the allegations are cited.			plan of correction.		
	G 11 . D. 2000	C=10 0 1					
	-	6713- Substantiated. No					
	deficiencies related	I to the allegations are cited.					
	G 1. 37	1 17 110 2021					
	Survey dates: Nove	ember 17 and 18, 2021					
	F 11' 1 0	00122					
	Facility number: 0						
	Provider number:						
	AIM number: 100	200720					
	Census Bed Type:						
	SNF/NF: 89						
	Total: 89						
	10141. 69						
	Census Payor Type						
	Medicare: 7						
	Medicaid: 69						
	Other: 13						
	Total: 89						
	10						
	These deficiencies	reflect State Findings cited in					
	Those deficiencies	refrest State I manige ched in					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV. A. BUILDING 00 COMPLETED B. WING 11/18/2021					
	PROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) 0 IAC 16.2-3.1.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Trach Suctioning § 483.25(i) Respiratory tracheostomy care The facility must e needs respiratory tracheostomy care is provided such o professional stand comprehensive pe the residents' goa 483.65 of this sub Based on observativ interview, the facili tracheostomy suppl tubes, were availab suctioning was perf of 3 residents revier (Residents E) Finding includes: On 11/17/21 at 1:4: observed in bed with and a person from the bedside. At that time respiratory distress therapist she needed therapist left the roa attempting to sit on sitting up, she pickey out phlegm from he	repleted on 11/22/21. repleted on 11/22/21.	F 0695	1) Resident B was not harmed by the alleged deficipractice. A tracheostomy of same size and a tracheostom one size smaller was placed resident's room with other necessary equipment for immediate use as needed. Unotification of suctioning technique the physician and family were made aware and the nurse was provided education on tracheostomy suctioning and a competenc was completed. 2) All other residents that have tracheostomies have the potential to be affected. An audit was conducted on all residents with tracheostomy	the ny in pon y		
	room and washed h She was wearing a	er hands with soap and water. regular face mask and a face . She started to look in the		to ensure that there was the appropriate tracheostomy equipment. Anyone found			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	l í	JILDING	onstruction 00	(X3) DATE S COMPL 11/18/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	suction kit. She oped both hands, and lood drawer. She remove room. The resident but was now lying it elevated and eyes of trach oxygen mask oxygen flow rate was spare trach size 4 in inner cannulas, and across from the resident of the company of	drawers and removed a greed it up, donned gloves to ked again in the top nightstand ed her gloves and left the continued to have distress in the bed with her head osed. The resident had a over her tracheostomy. The as set at 5 liters. There was 1 is a box, a box of disposable 1 trach cleaning kit observed dent, on the dresser, back in elevision set. There was a in piece) in an opened package on machine and the oxygen mine. There were no other stion the resident's mouth im. The nurse returned with 4 line and removed another drawer and donned the set. She suctioned the set of the success of the succes			without needed equipment has the tracheostomy equipment placed in the room immediated. 3) The Regional Respirator Therapist manager educated licensed nurses on tracheostomy suctioning, set-up with emphasis on additional emergency equipment at bedside, and a return demonstration competency was completed each licensed nurse. 4) The DON/Designee will audit all residents identified with a tracheostomy rooms for needed equipment 3 x weekly for 4 weeks, then 2 times weekly for 4 weeks, then 1 x weekly for 4 weeks. The DON/Designee will audit observation 3 licensed nurse perform suctioning on a tracheostomy patient 3 x weekly for 4 weeks, 2 times weekly for 4 weeks, 2 times weekly for 4 weeks, and 1 x weekly for 4 weeks. 5) The Director of Nursing or Designee will report to the QAPI committee findings and the QA committee findings and the QA committee will determine when compliance achieved or if ongoing monitoring is required.	ely. ry all on or y via	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		ILDING	<u>00</u>	COMPL 11/18/	ETED	
	ROVIDER OR SUPPLIER AKES HEALTHCAI		2300 GF	DDRESS, CITY, STATE, ZIP CODE REAT LAKES DR N 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	sit with the resident.					
	she was aware she had mouth with the same suctioned the trache tubing. The LPN in "I did what I had to there was no normal resident in the room yanker. The room veracheostomy supplishand to find the item supplies that were not not not supplies that were not	es every where and it was as she needed and there were of available for use. p.m., the resident was the side of the bed in no She was alert and oriented family. Her oxygen was set minute. There was still only by in the room. esident at that time, indicated the inner cannula on a daily been there. 1 on 11/17/21 at 3:40 p.m., haware what size trach was in the was more than one. She that the oxygen flow rate was in the the theory of the oxygen was and indicated the oxygen was apply indicated the oxygen was apply indicated the oxygen tracheostomy in the archeostomy in the archeostomy care in the past but a				
	long time ago. LPN	1 had been taking care of the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO JILDING	NSTRUCTION	COMPL			
ANDILAN	OF CORRECTION	155218	B. W		00	11/18/		
		133216	В. "			11/10/	2021	
NAME OF F	PROVIDER OR SUPPLIEF	8		1	ADDRESS, CITY, STATE, ZIP CODE			
			2300 GREAT LAKES DR					
GREAT	LAKES HEALTHCA	RE CENTER		DYER, I	IN 46311			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	resident all day.							
		V 2 on 11/17/21 at 3:45 p.m.,						
		iken care of the resident for						
	_	ays on the evening shift and						
	l -	g treatment last night. She						
		ot that familiar with "trachs"						
		elp she would get another						
	_	LPN 2 stated, "I did not look at						
		en concentrator yesterday s in the room. It was a busy						
	1	in the room. It was a busy indicated she would like						
	~	ecause it had been a long time						
		ed with "trachs." The resident						
		nnula changed yesterday						
		st suctioned her and did not						
		he was not familiar on how to						
	do that.	ne was not familiar on now to						
	do man							
	The record for Resi	dent E was reviewed on						
	11/17/21 at 2:45 p.i	n. The resident was admitted						
	_	/14/21. Diagnoses included,						
	but were not limited	d to, heart failure, high blood						
	pressure, chronic re	spiratory status,						
	tracheostomy, and a	anxiety.						
	Physician's Orders,	dated 11/14/21, indicated						
	<i>'</i>	rile lubrication. Inspection of						
		nge or clean daily and as						
		th normal saline for thick						
	_	trach dressing and trach ties						
		for increased secretions.						
		lation of lungs prior to						
		trach using ambu bag (Deep						
		ch, Ambu bag, oxygen (e.g.,						
		n canister and catheters in						
		Frach type and size #4 and one						
		obturator, lubrication kit, and						
		ff inflation at bedside at all						
	umes. 6 litters of 6	xygen via trach continuously.						

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		155218	B. W	ING		11/18/	2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	full PPE (Personal I	dated 11/16/21, indicated Protective Equipment) udes the N-95 mask with						
	resident had an alter related to chronic re	d 11/15/21, indicated the ration in respiratory status espiratory failure. A nursing evide oxygen therapy as						
	resident was current care. A nursing app	d 11/16/21, indicated the sily receiving tracheostomy broach was to keep extra current size and one size						
	11/18/21 at 9:00 a.m trachs and all the trainside the top drawe there should have be saline, suctioning king yankers for suctioning the successive was completed. Respiratory Therapis when they had 2 training were admitted to the respiratory therapy oxygen for the facil sure the oxygen was time, the respiratory	Director of Nursing (DON) on and, indicated she set up all the arch equipment. She indicated for of the resident's night stand deen all the supplies including atts, the spare trach, and the ang. Training for 90% of the ed by the Corporate ast Consultant in August 2021 och residents. LPN 2 was not When new trach residents are facility, the contracted company who supplied the aity would come in and make as set up correctly. At this are therefore the track of the company had not unate the oxygen situation for						
		with the DON on 11/18/21 ated the inservice training for was provided by the						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA				ONSTRUCTION	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL		
		155218	B. W	ING		11/18/	2021	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR					
GREAT L	AKES HEALTHCA	RE CENTER		DYER, I	IN 46311			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		ry Therapist on 8/6/21 and						
	•	inserviced/trained on trach						
		as tracheostomy care,						
	_	ders, set up, point click care						
	batch orders. LPN							
	participate in the tra	ınıng.						
	This Federal tag rela	ates to Complaint						
	IN00364158.	1						
	2.1.47(-)(()							
	3.1-47(a)(6)							
F 0880	483.80(a)(1)(2)(4)	(e)(f)					,	
SS=D	Infection Prevention	on & Control						
Bldg. 00	§483.80 Infection	Control						
	The facility must e	stablish and maintain an						
	•	n and control program						
		le a safe, sanitary and						
		nment and to help prevent						
	•	and transmission of						
	communicable dis	eases and infections.						
	§483.80(a) Infection	on prevention and control						
	program.							
	_	stablish an infection						
	-	ntrol program (IPCP) that						
		minimum, the following						
	elements:							
	§483.80(a)(1) A sy	stem for preventing,						
		ng, investigating, and						
	controlling infection	ns and communicable						
	diseases for all res	sidents, staff, volunteers,						
	visitors, and other	individuals providing						
	services under a c	ontractual arrangement						
	based upon the fa	-						
		ng to §483.70(e) and						
	following accepted	I national standards;						
	§483.80(a)(2) Writ	ten standards, policies,						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′		INSTRUCTION	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. W	JILDING	00	COMPL		
		155218	B. W.	ing		11/18/	2021	
NAME OF P	ROVIDER OR SUPPLIER	-		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
101111111111111111111111111111111111111	no vident on dori elle.		2300 GREAT LAKES DR					
GREAT L	AKES HEALTHCA	RE CENTER		DYER, I	IN 46311			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDENCE NEARLOS CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	and procedures fo	or the program, which must						
	include, but are no	ot limited to:						
	(i) A system of sur	veillance designed to						
	identify possible c	ommunicable diseases or						
	infections before t	hey can spread to other						
	persons in the fac	ility;						
	(ii) When and to w	hom possible incidents of						
	communicable dis	ease or infections should						
	be reported;							
	, ,	transmission-based						
	•	followed to prevent spread						
	of infections;							
	` '	isolation should be used						
		uding but not limited to:						
		duration of the isolation,						
		ne infectious agent or						
	organism involved							
	. , , .	that the isolation should be						
		e possible for the resident						
	under the circums							
	` '	nces under which the pit employees with a						
		ease or infected skin						
		t contact with residents or						
		contact will transmit the						
	disease; and	Contact will transmit the						
	· ·	ene procedures to be						
	. ,	nvolved in direct resident						
	contact.							
	§483.80(a)(4) A s	ystem for recording						
	- , , , , ,	d under the facility's IPCP						
	and the corrective	actions taken by the						
	facility.							
	§483.80(e) Linens							
		andle, store, process, and						
	· ·	as to prevent the spread						
	of infection.							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE SU	DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLET	ED
		155218	B. Wl	NG		11/18/20)21
	PROVIDER OR SUPPLIE		•	2300 G	ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DR IN 46311	•	
(X4) ID	CHMMADVC	TATEMENT OF DESIGNATES	1	ID	T		(V5)
PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	DATE
1710	§483.80(f) Annua	·		1710			DATE
	\ '	nduct an annual review of					
	1	ate their program, as					
	necessary.	ato their program, as					
	1	on, record review, and	F 08	880	F 880	1	12/09/2021
		ity failed to ensure infection	1 00	,00		'	12/07/2021
	control guidelines	-			Corrective actions		
		ding those to prevent and/or			accomplished for those		
	_	, related to not using the			residents found to be affected	d	
	appropriate persona	al protective equipment (ppe)			by the alleged deficient		
	during tracheostom	y care and suctioning and the			practice:		
	placement of woun	d treatment materials in a			LPN 1 was educated on prope	er	
	resident's bed for 1 of 1 observations of				procedure for tracheostomy care		
	tracheostomy care and 1 of 1 observations of				and the use of N95 when cari	ng	
	wound care. (Resid	dents E and K)			for tracheostomy patients.		
	Findings include:				Wound nurse was educated o	n	
					infection control practices		
	1. On 11/17/21 at	1:45 p.m., Resident B was			regarding wound care, includi	ng,	
		th a tracheostomy, and a			but not limited to dressing		
	_	erapy department was at her			changes		
		ne the resident was in			Identification of other reside	nts	
		and indicating to the			having the potential to be		
	_	d to be suctioned. The			affected by the same alleged		
	_	om and the resident was			deficient practice and		
		the side of the bed. After			corrective actions taken: All		
		ed up a cup and started to spit			residents have the potential to		
		er mouth. LPN 1 entered the			affected by this alleged deficie	erit	
		er hands with soap and water.			practice.		
		regular face mask and a face . She started to look in the			The DON or designee will		
		d drawers and removed a			complete the following:		
		ened it up, donned gloves to			Staff involved will educa	ated	
		oked again in the top			in infection control practices		
		She removed her gloves and			regarding wound care, including	ng,	
		resident continued to have			but not limited to dressing	<i>''</i>	
	distress but was no	w laying in the bed with her			changes.		
		eyes closed. The nurse			o Competency: Wound		
		tles of normal saline and			Dressing Change		
	removed another su	action kit from the drawer and					

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PRINTED: 12/09/2021 FORM APPROVED OMB NO. 0938-0391

DENTIFICATION NAME: In SECTION OF EXPONDED OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311 SUMMARY STATEMENT OF DEPICIENCES DYER, IN 46311 SUMMARY STATEMENT OF DEPICIENCES PRIETR TAG REGIT ATORY OR IS DEPINITIVEN. INFORMATION) domed the gloves to both hands. She suctioned the resident strate-beatomy and the resident immediately sat up and indicated she could not breathe. LPN 1 told her to try and relax and settle dwon. She suctioned upain and the resident sat on the side of the bed and again said she could not breath. LPN 1 said "let me suction to your mouth." The resident agreed and the LPN sing the same suction to big as she did with the trachestsemy, suctioned the resident's mouth, She let the resident rest a minute and indicated to her she was going to change her inner cannula. The LPN removed the inner cannula and took unother from the box and placed it into the resident's trachestomy. The resident indicated she was better and wanted to sit up for awhile. The LPN performed the entire sident indicated she was better and wanted to sit up for awhile. The LPN performed the entire resident indicated she was better and wanted to sit up for awhile. The LPN performed the entire resident indicated she was better and wanted to sit up for awhile. The LPN performed the entire procedure while only wearing a surgical face mask. There was no ppe outside of the resident's room or nearby. The record for Resident E was reviewed on 11/17/21 at 2/45 pm. The resident was admitted to the facility on 11/14/21. Diagnoses included, but were not limited to, heart failure, high blood pressure, chronic respiratory status, tracheostomy, and anxiety. The record for Resident E was reviewed on 11/18/21 at 70.00 a.m., indicated the nurses were to be waring a NNS fee mask whith streach care. Interview with the Director of Nursing on 11/18/21 at 70.00 a.m., indicated the nurses were to be waring a NNS fee mask with the succious of the resident E was reviewed to the resident E working and E w	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D.			(X3) DATE SURVEY	
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to be wearing an N95 face mask when suctioning the resident.2. On 11/18/21 at 9:05 a.m., will be monitored to ensure the alleged deficient practice does		-				How the corrective measure	s
the resident.2. On 11/18/21 at 9:05 a.m., alleged deficient practice does							-
		_	_				
						not recur:	

PRINTED: 12/09/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155218	B. W	NG		11/18/	2021
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
					REAT LAKES DR		
GREAT L	AKES HEALTHCA	RE CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
1710		The nurse indicated she	+	1110	After the IDT and Infection		DITTE
						Λ	
	_	ressing on the right side			Preventionist completed the R	CA	
		t, then do the dressing to his			and LTC infection control		
		se placed two open foam			assessment, training identified		
		e of clobetasol cream (a			above was implemented to fac	ility	
		treat skin conditions) on a			staff. The training will be		
		placed it on the bed. She then			conducted by the DON, IP or		
		disposable gloves, two open			Medical Director with		
	packages of calciun	n alginate (wound dressing			documentation of completion.		
	material) and a blac	k marker directly on the					
	resident's bed. The	nurse removed the calcium			To ensure Infection Control		
	alginate from an op	en package and applied			Practices are maintained, the		
	clobetasol cream on	nto it, she then placed the			following monitoring will be		
	cream directly on th	ne bed. She went to her			implemented.		
	treatment cart and r	etrieved two open packages			•		
		soaking in normal saline and			1. The IP nurse/DON/Designed	е	
		s directly on the bed. She			will monitor each solution and		
		from the open package,			systemic change identified in		
	_	nt's wound and applied the			RCA and as noted above, daily	v or	
		noved to the resident's right			more often as necessary for 6	,	
		a box of gloves and a bottle of			weeks and until compliance is		
		placed them directly on the			maintained.		
	_	he wound with the gauze and			mamamou.		
	applied the dressing	C			Ensure staff execute infection		
	applied the dressing	ş.			control practices regarding		
	The resident record	was reviewed on 11/18/21 at			resident wound care – dressing	a	
		was admitted on 1/8/21.				9	
		, but were not limited to,			changes Ensure staff execute correct		
	_						
		nd chronic obstructive			procedure and wearing of N95		
	pulmonary disease.				during trach care		
	A TOLE	1 , 110/10/01 : 1 1 .					
	-	, dated 10/19/21, indicated to			O The ID was a /DON/D		
		nd right chest area with			2. The IP nurse/DON/Design		
		at dry, apply clobetasol cream			will complete daily visual round		
	_	e, then cover with a foam			throughout the facility to ensur		
	dressing daily.				staff are practicing appropriate		
					Infection Control Practices and	i	
		Wound Care Nurse after the			complying with the solutions		
		indicated she understood the			identified as above. This will		
	bed was not a clean	surface.			occur for 6 weeks and until		
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

95II11

Facility ID: 000123

If continuation sheet

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PRINTED: 12/09/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218			A. BUILDING <u>00</u>			COMPL	X3) DATE SURVEY COMPLETED 11/18/2021	
NAME OF PROVIDER OR SUPPLIER GREAT LAKES HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	11/18/21 at 9:27 a. were to be prepare	Director of Nursing on m., she indicated treatments d at her treatment cart and that e set directly on the bed.			compliance is maintained. Ensure staff execute infection control practices regarding resident wound care – dressing changes Ensure staff execute correct procedure and wearing of N95 during trach care			
					Quality Assurance and Performance Improvement (QAPI): The facility through the QAPI program, will review, update at make changes to the DPOC at needed for sustaining substant compliance for no less than 6 months.	S		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 95II11 Facility ID: 000123 If continuation sheet Page 12 of 12