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	02/12/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00427499. Complaint IN00427499 - Federal/state deficiencies related to the allegations are cited at F686. Survey date: 2/12/24 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Census Bed Type: SNF/NF: 122 Total: 122 Census Payor Type: Medicare: 12 Medicaid: 83 Other: 27 Total: 122 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/14/24.	F 0000	**Great Lakes Healthcare** **Complaint Survey: 2-12-2024** **F686- Treatment/SVS to Prevent/Heal Pressure** 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.**	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop			

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

Jason Eastlund | Executive Director | 03/01/2024

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	pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure residents' with pressure ulcers received the necessary treatment and services to promote healing, related to dressings not present, treatments not completed as ordered, and preventative interventions not completed correctly, for 3 of 3 residents reviewed for pressure ulcers. (Residents C, B, and D) Findings include: 1) During an observation, on 2/12/24 at 8:54 a.m., Resident C was lying on her left side. LPN 1 indicated the resident was admitted into the facility with multiple pressure ulcers. She then unfastened the resident's incontinence brief and pulled the urine soaked brief away from the skin. She indicated there was no dressing present on the pressure area on the sacral area. The sacral area was observed to have two pressure areas that were pinkish-red and without drainage. There was no dressing located in the brief. She then reapplied the soiled brief, and indicated she would need to have help with the care. She indicated the Wound Nurse would not be in the facility today, but the Wound Specialist was scheduled to visit today. During an interview, on 2/12/24 at 8:57 a.m., CNA 2 indicated she had checked the resident around 6	F 0686	**Great Lakes Healthcare Complaint Survey: 2-12-2024** **F686- Treatment/SVS to Prevent/Heal Pressure Ulcers** 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 B, C and D were not harmed by the alleged deficient practice. B, C and D Residents were assessed and had no negative findings to the alleged deficient practice. 2 All residents, with pressure ulcers, have had their pressure ulcers assessed to ensure no adverse effects were noted related to the alleged deficient practices.	03/02/2024

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	a.m. and she was dry. She indicated the resident had a dressing on at that time. Employee 1 indicated there was a dressing on the lower right buttock, and not on the sacral area. During an interview, on 2/12/24 at 9:25 a.m., the Director of Nursing (DON) indicated the Wound Specialist was unable to visit the facility on 2/12/24. During an observation, on 2/12/24 at 9:37 a.m., LPN 1, CNA 2, CNA 3, and RN 4 entered the room to complete care. RN 4 removed the urine soaked brief. She then washed the sacrum with incontinent wipes and a washcloth/towel. LPN 1 then used skin prep and applied a hydrocolloid dressing (moist healing dressing). Wound wash was not used prior to the dressing being applied. Resident C's record was reviewed on 2/12/24 at 2:17 p.m. The diagnoses included, but were not limited to, stroke. An Admission Minimum Data Set (MDS) assessment, dated 1/5/24, indicated a severely impaired cognitive status, required maximum to dependent care needed for all activities of daily living (ADLs), was always incontinent of urine and frequently incontinent of bowel, and had eight unstageable (full-thickness pressure injuries in which the base is obscured by slough and/or eschar) pressure injuries present. A Care Plan, dated 12/29/23, indicated pressure ulcers were present. The interventions included, treatments would be completed as ordered. The most recent Wound Specialist Progress Note, dated 2/5/24, indicated the sacrum wound was unstageable and improving without		All residents with a low air loss mattress were audited to ensure the setting is correct per the manufacture guidelines. All resident's with wounds were assessed to validate ordered wound care treatments are in place and completed per the physician's order. 3 DON/Designee has educated all Nursing Staff on the low air loss mattress settings and how each should be set based off manufacture guidelines. All Nursing staff was educated that when a dressing comes off during resident care, that the CNA's must inform the attending nurse so that the dressing can be replaced. All Licensed Nurses were educated that they must clean every wound, with the physician ordered solution, prior to placing a clean dressing. All Licensed Nurses were educated that they must complete and document all treatments on their shift daily. 4 DON/Designee will audit 5 random residents with wounds to 3 X per week, to ensure air mattress is on appropriate setting, dressings are in place, treatments are completed per physician order, documentation is on the TAR. DON/Designee will report on audits monthly to the interdisciplinary team for 6 months	

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	complications. The size was 2 centimeters by 1.8 centimeters with a depth of 0.1 centimeters. Subcutaneous tissue was exposed. The treatment recommendations were to cleanse the area with wound cleanser, then apply a hydrocolloid dressing to the base of the wound, and change the dressing three times a week and as needed. A Physician's Order, dated 1/31/24, indicated the sacrum wound was to be cleansed with wound cleanser, then covered with a hydrocolloid dressing, three times a week and as needed. The Treatment Administration Record (TAR), dated 2/2024, indicated the treatment to the sacrum pressure area had last been done on Friday February 9, 2024. 2) During an observation, on 2/12/24 at 9:03 a.m., LPN 1 indicated Resident B had been admitted into the facility with multiple pressure areas. The low air loss bed he was lying on, was set for 350 pounds and firm. During an observation, on 2/12/24 at 10:42 a.m., the low air loss bed remained set for 350 pounds and firm. During an observation, on 2/12/24 at 3:22 p.m., the low air loss bed remained set for 350 pounds and firm. During an observation, on 2/12/24 at 3:34 p.m., the Administrator acknowledged the low air loss bed was set at 350 pounds. Resident B's record was reviewed on 2/12/24 at 10:50 a.m. The diagnoses included, but were not limited to, stroke.		during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	An Admission MDS assessment, dated 12/14/23, indicated he was admitted from an acute care hospital, had a severely impaired cognitive status, an impairment of the bilateral upper and lower extremities, required maximum to dependent assistance with all ADL's (activities of daily living). He was admitted with the following pressure ulcers: one stage 2 (open superficial wound), two stage 3's (deeper tissue open areas) and four unstageable pressure areas and a pressure reducing mattress was used. A Care Plan, dated 1/25/24, indicated the pressure ulcers were present. The interventions included an off-loading mattress would be provided. A Physician's Order, dated 1/31/24, indicated a pressure reducing/relieving mattress was to be used. The most current Wound Specialist Progress Note, dated 2/1/24, indicated an alternating air/low air loss mattress was being used for pressure redistribution and the staff were to ensure the settings were maintained at the appropriate level based on the resident's needs and body habitus (physical build). The resident's most current weight, dated 1/31/24, was 124.9 pounds, which was not close to the current mattress setting of 350 pounds. 3) During an interview, on 2/12/24 at 10:26 a.m., LPN 5 indicated Resident D had a pressure area on the coccyx. The resident refused to allow an observation of the area. Resident D's record was reviewed on 2/12/24 at 3:02 p.m. The diagnoses included, but were not limited to, diabetes mellitus.			

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	A Quarterly MDS assessment, dated 11/28/24, indicated an intact cognitive status, was dependent with toileting, was always incontinent of bowel and bladder, and had no unhealed pressure ulcers. A Care Plan, dated 9/14/23, indicated a risk for pressure ulcers. The interventions included to administer treatments as ordered. A Care Plan, dated 12/14/23, indicated a behavioral problem of refusal of care at times. The interventions included to administer medications as ordered and educate the resident. The Physician's Orders, dated 12/21/23, indicated zinc oxide 20% (barrier cream) was to be used on the right lower buttock for MASD (Moisture-Associated Skin Damage) with every incontinence change, three times a day for wound care. The zinc oxide 20% was to be used for the reopened area on the left buttock every shift. The TAR, dated 2/2024, indicated the left buttock treatment had not been completed on the night shift on February 7 and 10, 2024 and the treatment for the right buttock had not been completed on the evening shift on February 7, 2024 and the night shift on February 10, 2024. Documentation in the Nurses' Progress Notes for February 7 and 10, 2024, had not indicated the resident refused the treatments as ordered. The DON was notified on 2/12/24 at 3:27 of the treatments to the buttocks not provided as ordered. No further information was provided. A facility policy, titled, "Skin Care & Wound			

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	Management", revised on 5/31/22, and received from the DON as current, indicated, treatment plans and interventions would be monitored. This citation relates to Complaint IN00427499. 3.1-40(a)(2)			