	SURVEY
NAME OF PROVIDER OR SUPPLIER     2300 GREAT LAKES DR       GREAT LAKES HEALTHCARE CENTER     DYER, IN 46311       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIE (EACID DEFICIENCY MUST BE PRECEDED BY FOLL TAG     D       PRETX TAG     REGULATORY OR LSC IDENTIFYING INFORMATION     PB       0000     This visit was for the Investigation of Complaint IN00427499.     PG       Complaint IN00427499 Federal/state deficiencies related to the allegations are cited at F686.     F 0000     Great Lakes Healthcare Complaint Survey: 2-12-2024       Facility number: 000123 Provider number: 155218 AIM number: 10266720     F 0000     Great Lakes Healthcare Complaint Survey atte: 2/1/2/4       Census Bed Type: Total: 122     Total: 122     Total: 122       Total: 122     Total: 122     Total: 122       Total: 122     This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.     Total: 122       Total: 122     This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.     Total: 122       Total: 122     This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.     Total: 122       Total: 122     This deficiency reflects state Findings cited in accordance with 410 IAC 16.2-3.1.     Total: 122       Total: 122     This deficiency reflects state Findings cited in accordance with 410 IAC 16.2-3.1.     Total: 122       Total: 122     Total: 122       Treatment/Svos to Prevent/Heal Pre	
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Bldg. 00       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-	
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§483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	
Based on the comprehensive assessment of a resident, the facility must ensure that-	
a resident, the facility must ensure that-	
professional standards of practice, to prevent	
pressure ulcers and does not develop	

# LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURETITLE(X6) DATEJason EastlundExecutive Director03/01/2024

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. PRINTED:

03/05/2024

#### PRINTED: 03/05/2024 FORM APPROVED

OMB NO. 0938-039

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 02/12/2024 155218 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2300 GREAT LAKES DR GREAT LAKES HEALTHCARE CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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. F 0686 Great Lakes Healthcare 03/02/2024 Based on observation, record review, and Complaint Survey: 2-12-2024 interview, the facility failed to ensure residents' with pressure ulcers received the necessary F686- Treatment/SVS to treatment and services to promote healing, related Prevent/Heal Pressure Ulcers to dressings not present, treatments not Preparation and execution of this completed as ordered, and preventative plan of correction does not interventions not completed correctly, for 3 of 3 constitute admission or agreement residents reviewed for pressure ulcers. (Residents by this provider of the truth of the C, B, and D) facts alleged or conclusions set forth in the Statement of Findings include: Deficiencies. The plan of correction is prepared and 1) During an observation, on 2/12/24 at 8:54 a.m., executed solely because it is Resident C was lying on her left side. LPN 1 required by the provisions of indicated the resident was admitted into the federal and state law. facility with multiple pressure ulcers. She then The facility cordially requests unfastened the resident's incontinence brief and paper compliance regarding pulled the urine soaked brief away from the skin. alleged deficient practices. She indicated there was no dressing present on the pressure area on the sacral area. The sacral Resident B, C and D were 1 area was observed to have two pressure areas not harmed by the alleged that were pinkish-red and without drainage. There deficient practice. B, C and D was no dressing located in the brief. She then Residents were assessed and had reapplied the soiled brief, and indicated she would no negative findings to the alleged need to have help with the care. She indicated the deficient practice. Wound Nurse would not be in the facility today, but the Wound Specialist was scheduled to visit All residents, with pressure 2 today. ulcers, have had their pressure ulcers assessed to ensure no During an interview, on 2/12/24 at 8:57 a.m., CNA adverse effects were noted related 2 indicated she had checked the resident around 6 to the alleged deficient practices. CN0P11

Facility ID: 000123

If continuation sheet

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Event ID:

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

ENTERS FO	R MEDICARE & MEDI	CAID SERVICES				ON	4B NO. 0938-039
	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 155218		r í	JILDING	DNSTRUCTION 00	X3) DATE SURVEY COMPLETED 02/12/2024	
	PROVIDER OR SUPPLIE			2300 G	ADDRESS, CITY, STATE, ZIP COD REAT LAKES DR IN 46311		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO	)N	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	a.m. and she was dry. She indicated the resident				All residents with a low air	oss	
	had a dressing on			mattress were audited to en			
	indicated there was a dressing on the lower right				the setting is correct per the		
	buttock, and not on the sacral area.				manufacture guidelines. All		
					resident's with wounds wer		
	During an intervie			assessed to validate ordere			
		ng (DON) indicated the Wound			wound care treatments are		
	Specialist was una $2/12/24$ .	ble to visit the facility on			place and completed per th physician's order.	ie	
	During an observa	ntion, on 2/12/24 at 9:37 a.m.,			3 DON/Designee has		
	LPN 1, CNA 2, C	NA 3, and RN 4 entered the room			educated all Nursing Staff	on the	
	to complete care.	RN 4 removed the urine soaked			low air loss mattress setting	gs and	
	brief. She then wa	shed the sacrum with			how each should be set ba	sed off	
	incontinent wipes	and a washcloth/towel. LPN 1			manufacture guidelines. All		
		p and applied a hydrocolloid			Nursing staff was educated	l that	
		aling dressing). Wound wash			when a dressing comes off	during	
	was not used prior	to the dressing being applied.			resident care, that the CNA must inform the attending r		
	Resident C's recor	d was reviewed on 2/12/24 at			so that the dressing can be		
	2:17 p.m. The diag	gnoses included, but were not			replaced. All Licensed Nur		
	limited to, stroke.				were educated that they me		
					clean every wound, with the		
	An Admission Mi	nimum Data Set (MDS)			physician ordered solution,		
		1/5/24, indicated a severely			placing a clean dressing. A		
		e status, required maximum to			Licensed Nurses were edu		
	dependent care ne	eded for all activities of daily			that they must complete an	d	
	living (ADLs), wa	s always incontinent of urine			document all treatments on		
	and frequently inc	ontinent of bowel, and had			shift daily.		
		(full-thickness pressure injuries					
		is obscured by slough and/or			4 DON/Designee will a	udit 5	
	eschar) pressure in	njuries present.			random residents with wou 3 X per week, to ensure air		
	A Care Plan dated	d 12/29/23, indicated pressure			mattress is on appropriate		
		at. The interventions included,			dressings are in place, trea	-	
	-	be completed as ordered.			are completed per physicia		
	acamento would	et compreted as ordered.			documentation is on the TA		
	The most recent W	Vound Specialist Progress Note,			DON/Designee will report of		
		cated the sacrum wound was			audits monthly to the	···	
	unstageable and in				interdisciplinary team for 6	months	

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Event ID: CN0P11 Facility ID: 000123

If continuation sheet Page 3 of 7

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	R MEDICARE & MEDIC NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	ONSTRUCTION	(X3) DAT	MB NO. 0938-0 E SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER				BUILDING	00	× ,	PLETED
		155218	B. WING			02/12/2024	
NAME OF	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD			COD	
	LAKES HEALTHCA		2300 GREAT LAKES DR DYER, IN 46311				
	1				1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETI
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION complications. The size was 2 centimeters by 1.8			TAG			DATE
	complications. The size was 2 commencers by 1.8 centimeters with a depth of 0.1 centimeters. Subcutaneous tissue was exposed. The treatment recommendations were to cleanse the area with				during QAPI Meeting. The IDT wi determine if the audits are		
					necessary to continue		
					months with 100% cor		
	wound cleanser, the	n apply a hydrocolloid			achieved.		
	dressing to the base	of the wound, and change					
	the dressing three ti	mes a week and as needed.					
	A Physician's Order, dated 1/31/24, indicated the						
		to be cleansed with wound					
		red with a hydrocolloid					
	dressing, three time	s a week and as needed.					
		ninistration Record (TAR),					
		ated the treatment to the					
	Friday February 9, 2	a had last been done on 2024.					
		vation, on 2/12/24 at 9:03 a.m.,					
		sident B had been admitted					
	-	n multiple pressure areas. The					
	pounds and firm.	was lying on, was set for 350					
	During an observation	ion, on 2/12/24 at 10:42 a.m.,					
	the low air loss bed and firm.	remained set for 350 pounds					
	-	ion, on $2/12/24$ at 3:22 p.m., the					
	firm.	nained set for 350 pounds and					
		ion, on 2/12/24 at 3:34 p.m., the					
	Administrator ackn was set at 350 poun	owledged the low air loss bed ds.					
		was reviewed on $2/12/24$ at					
	10:50 a.m. The diag limited to, stroke.	gnoses included, but were not					

PRINTED: 03/05/2024

03/05/2024 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 02/12/2024 155218 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2300 GREAT LAKES DR GREAT LAKES HEALTHCARE CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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

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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observation of the area.

Event ID:

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155218		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/12/2024	
	PROVIDER OR SUPPLI		2300	et address, city, state, zi GREAT LAKES DR R, IN 46311	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL NR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLETIO DATE
	indicated an intact dependent with to of bowel and blad pressure ulcers. A Care Plan, date pressure ulcers. The administer treatmon A Care Plan, dated behavioral problem interventions inclu- as ordered and edu The Physician's O	d 12/14/23, indicated a n of refusal of care at times. The uded to administer medications				
	incontinence chan care. The zinc oxi	ttock for MASD ated Skin Damage) with every ge, three times a day for wound de 20% was to be used for the the left buttock every shift.				
	treatment had not shift on February for the right butto	/2024, indicated the left buttock been completed on the night 7 and 10, 2024 and the treatment ck had not been completed on on February 7, 2024 and the ruary 10, 2024.				
	February 7 and 10	the Nurses' Progress Notes for 9, 2024, had not indicated the ne treatments as ordered.				
	treatments to the b	ified on 2/12/24 at 3:27 of the puttocks not provided as er information was provided.				
	A facility policy,	titled, "Skin Care & Wound				

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         155218		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			X3) DATE SURVEY COMPLETED 02/12/2024	
	PROVIDER OR SUPPLIER			2300 G	ADDRESS, CITY, STATE, ZIP COD REAT LAKES DR IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	(X5) COMPLETION DATE
	from the DON as cu plans and interventi	eed on 5/31/22, and received urrent, indicated, treatment ons would be monitored. to Complaint IN00427499.					

CN0P11 Facility ID: 000123