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	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 Complaints IN00353846, IN00354167, IN00354312 and IN00355926. Complaint IN00353846 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00354167 - Substantiated. Federal/ State deficiencies related to the allegations are cited at F686. Complaint IN00354312 - Substantiated. Federal/ State deficiencies related to the allegations are cited at F684. Complaint IN00355926 - Substantiated. No deficiencies related to the allegation are cited. Survey dates: June 28 & 29, 2021 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Census Bed Type: SNF/NF: 85 Total: 85 Census Payor Type: Medicare: 4 Medicaid: 68 Other: 13 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Preparation execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts or alleged or conclusions set forth on the State of Deficiencies. The plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The plan of correction is submitted in order to respond to the allegation of non-compliance cited during survey on June 28st- 29rd 2021. Please accept this plan of correction as the provider's credible allegation of compliance. The facility would like to request a desk review for this survey.	

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

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	Quality review completed on 7/2/21.			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to implement resident-directed care and treatment consistent with the resident's comprehensive assessment and care plan, preferences, and physician orders, related to not administering medications as ordered for 2 of 3 residents reviewed for quality of care (Residents C and N) Findings include: 1. Resident C's record was reviewed on 6/28/21 at 11:11 a.m. The diagnoses included, but were not limited to, stroke, depression, hyperlipidemia, and hypertension. A Care Plan, dated 5/3/21 and revised on 6/7/21, indicated a mood problem related to depression. The interventions included, medications were to be administered as ordered by the Physician. A Care Plan, dated 5/3/21, indicated a cardiovascular problem related to hypertension and hyperlipidemia. The goals were to exhibit a reduction of cardiac symptoms and would be free from signs and symptoms of cardiac problems.	F 0684	**Corrective action for the residents found to have been affected by the deficient practice:** Resident's C and N were not harmed by the alleged deficient practice. Medications have been reconciled, and medication administration record audited to ensure there are no discrepancies. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** DON/Designee completed a 100% medication audit of all residents to ensure medications are available for each resident. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee has in-serviced all licensed nursing staff on the	07/20/2021

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	The interventions included, medications were to be administered as ordered by the Physician. The current Physician's Orders included the following: Atorvastatin (hyperlipidemia) 40 mg daily in evening Labetalol (anti-hypertensive) 200 mg twice a day, dated 5/1/21. Hydralazine (anti-hypertensive) 100 mg three times a day, dated 5/1/21 and 5/29/21. Mirtazapine (antidepressant) 7.5 mg at bedtime, dated 6/13/21. The Medication Administration Record (MAR), dated 5/2021, indicated by lack of initials, on 5/14/21 at 5 p.m., the hydralazine and labetalol were not administered as ordered by the Physician. The hydralazine was not administered at 5 p.m. on 5/21/21. The atorvastatin was not administered at 6 p.m. on 5/14/21. The MAR, dated 6/2021, indicated the mirtazapine 7.5 mg was not administered at 9 p.m. on 6/17/21. The atorvastatin was not administered at 9 p.m. on 6/2/21, 6/8/21, and 6/17/21. During an interview on 6/28/21 at 2:57 p.m., LPN 1 indicated if the medication was not signed as administered, they were not administered. 2. During an interview on 6/28/21 at 3:10 p.m., Resident N indicated medications sometimes do not get administered in the evening. Sometimes the nurse needed to be notified by the call light or sometimes they were not given at all. Resident N's record was reviewed on 6/29/21 at		facility policy of "Medication Administration," with emphasis on administering medications at designated times and proper documentation of medications given. **Corrective actions to be monitored to ensure the deficient practice will not recur:** DON/Designee will audit medication administration record 5x weekly for 4 weeks, 3x weekly for 4 weeks, then monthly for no less than 3 months or until compliance is met. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	9:20 a.m. The diagnoses included, but were not limited to, diabetes mellitus, congestive heart failure, atrial fibrillation, hypertension, depression, and gout. A Quarterly Minimum Data Set assessment, dated 6/11/21, indicated an intact cognitive status, received insulin, an antidepressant, an anticoagulant 7 days in the last 7 days and received 6 days of an antibiotic. A Care Plan, dated 1/11/21, indicated the resident complained of acute/chronic pain due to diabetes mellitus, gout, and GERD (gastric reflux disease). The Goal indicated relief from the pain would be verbalized. The interventions included, medication would be provided. A Care Plan, dated 3/18/21, indicated he had congestive heart failure with and without difficulty breathing. The goal was to have reduction in complications related to the congestive heart failure. The interventions included, medications were to be administered as ordered by the Physician. A Care Plan, dated 3/18/21, indicated unstable blood glucose levels related to diabetes mellitus. The interventions included, medications were to be administered as ordered by the Physician. A Care Plan, dated 6/16/21, indicated a diagnosis of diabetes mellitus related to impaired pancreatic functioning. The interventions included, insulin was to be administered as ordered by the Physician. A Care Plan, dated 3/18/21, indicated hypertension disease process. The interventions included, medications were to be administered as			

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	ordered by the Physician. A Care Plan, dated 3/31/21, indicated a risk for abnormal bleeding due to the use of an anticoagulant. The interventions included, anticoagulant medication would be provided as ordered by the Physician. A Care Plan, dated 3/18/21, indicated a diagnosis of GERD. The interventions included, medications would be administered as ordered by the Physician. A Care Plan, dated 6/3/21, indicated an abscess to the left underarm. The interventions included, an antibiotic would be administered as ordered by the Physician. The current Physician's Orders indicated: 3/17/21 to 6/5/21 - Admelog (insulin) 100 units/milliliter (ml), 20 units with meals. 6/6/21 - Admelog 100 units/ml, 22 units with meals. 3/17/21 to 6/5/21 - Basaglar Kwik Pen (insulin), 36 units at bedtime. 6/5/21 - Basaglar Kwik Pen, 60 units at bedtime\. 4/25/21 - famotidine (GERD) 10 milligrams (mg), one tablet twice a day. 1/9/21 - gabapentin (nerve pain), 300 mg three times a day. 1/9/21 - spironolactone (diuretic/anti-hypertensive) 25 mg daily. 1/9/21 - clopidogrel (blood thinner) 75 mg daily. 1/9/21 - metoprolol succinate ER (anti-hypertensive) 25 mg daily. 1/9/21 - isosorbide (heart medication) 20 mg three times a day. 1/9/21 - furosemide (diuretic) 80 mg, 1 swab by mouth in morning. 1/9/21 - Eliquis (blood thinner) 5 mg twice a			

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	day. 1/8/21 - doxazosin mesylate (anti-hypertensive) 4 mg at bedtime. 1/8/21 - atorvastatin (lipid lowering medication) 20 mg, 2 tablets in evening. 1/9/21 - allopurinol (gout) 100 mg daily. 6/3/21 9 a.m. to 6/10/21 - cephalexin (antibiotic) 500 mg twice a day for the abscess. The Medication Administration Record, dated 6/2021 indicated the following medications were not administered as ordered: The Allupurinal, metoprolol, spironolactone, Keflex, clopidogrel, and gabapetin were not given on 6/5/21 at 9 a.m. The furosemide, Eliquis, famatodine, and isosorbide were not given on 6/5/21 at 8 a.m. The Atorvastatin was not given at 9 p.m. on 6/2/21, 6/8/21, and 6/17/21. The Basaglar insulin, 36 units was not given at bedtime on 6/2/21. The Basaglar insulin 60 units at bedtime was not given on 6/8/21 and 6/17/21. The famatodine was not given at 5 p.m. on 6/3/21 and 6/5/21. The cephalexin 500 mg was not given at 6 p.m. on 6/3/21 and 6/5/21. The Admelog insulin 20 units with meals was not given at 8 a.m. on 6/5/21, 12 p.m. on 6/3/21 and 6/5/21, and 5 p.m. on 6/3/21 and 6/5/21. The Admelog insulin 22 units with meals was not given on 6/9/21 at 8 a.m., 12 p.m., and 5 p.m. and on 6/11/21 at 5 p.m. The gabapentin was not given at 3 p.m. on 6/3/21 and 6/5/21 and at 9 p.m. on 6/2/21, 6/8/21, and 6/17/21. The isosorbide was not given at 2 p.m. on 6/3/21 and 6/5/21. During an interview on 6/29/21 at 3:10 p.m., the			

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	Director of Nursing provided no further information. A facility policy, dated 8/2020, received from the Director of Nursing as current, titled, "Administration Procedures for All Medications", indicated after the administration of the medication, the MAR was to be signed. This Federal tag relates to Complaint IN00354312. 3.1-35(g)(2)			
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 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 provide necessary treatment and services consistent with professional standards of practice to promote healing of pressure ulcers related to treatments not completed as ordered by the Physician for 1 of 3 residents reviewed for pressure ulcers. (Resident H)	F 0686	**Corrective action for the residents found to have been affected by the deficient practice:** Resident H was not harmed by the alleged deficient practice. Wound nurse and NP have evaluated the residents' wounds to ensure	07/20/2021

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	Finding includes: During Orientation Tour on 6/28/21 at 5:00 a.m., Resident H was observed in bed. The resident's lower extremities were contracted. The resident was awake. LPN 3 removed the resident's blankets. A bandage, saturated with wet brownish colored drainage, was observed on the sacrum. A foul odor was present. The resident was also incontinent of stool. A strong urine odor was noted. The dressing was dated as last changed on 6/24/21. Saturated bandages were also present to both heels with dressings noted as last changed on 6/24/21. LPN 3 indicated the dressing changes were ordered to be completed every other day. The record for Resident H was reviewed on 6/28/21 at 9:55 a.m. Diagnoses included, but were not limited to, chenille and expressive aphasia following a cerebral infarction, unstageable pressure ulcers, vascular dementia, rheumatoid arthritis, legal blindness and falls. The Quarterly Minimum Data Set (MDS) assessment, dated 5/21/21, indicated the resident had no behaviors of rejection of care and was always incontinent of bowel and bladder. Range of motion on both upper and both lower extremities was impaired. A feeding tube was in place. A current Care Plan indicated Resident G was at risk for impaired skin integrity related to immobility, Covid-19, and current pressure ulcers to the right lateral ankle, right and left heels, sacrum and right buttock. Intervention included, but were not limited to, administer treatments as ordered, weekly skin checks,		appropriate treatment orders are in place and are consistent with standards of practice to promote healing of pressure ulcers. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** DON/Designee completed a house-wide audit and head to toe skin assessments were completed on all residents, any new findings were documented and treated per facility policy. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** Licensed nurses in-serviced on facility policy of “physician orders,” with emphasis on administering treatments as ordered by the physician. Licensed nurses completed a skills competency for wound dressing competency. **Corrective actions to be monitored to ensure the deficient practice will not recur:** DON/Designee will audit the treatment administration record 5x weekly for 4 weeks, 3x weekly for 4 weeks, then monthly for no less than 3 months or until compliance is met. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any	

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	evaluation existing wounds daily for change. Weekly Skin Assessments were completed on 6/24/21 for the sacrum, left heel, right heel and right outer ankle as follows: - Sacrum: House acquired pressure ulcer with no change in wound. Stage IV ulcer 5.0 x 5.2 x 0.2 cm. Resident displays pain with movement and during treatments. Medium amount of serous drainage with no odor noted. - Left Heel: No change in wound. Measures 9.2 x 7.4 x 0.1 cm Stage IV. Wound bed reddened with small amount of serous exudate. - Right Heel: Suspected deep tissue injury. Measures 8.4 x 9.2 cm. Skin intact with black eschar, has pain associated with wounds and pain medications as directed. Physician ordered wound care treatments were in place for the right lateral ankle, right medial heel, sacrum and left posterior heel as follows: 6/17/21- Right medial heel: cleanse with normal saline, pat dry, paint with skin prep, apply Hydrotherapy and cover with foam every evening shift and as needed for removal. 6/17/21- Right lateral ankle: cleanse with normal saline, pat dry, paint with skin prep and wet Hydrotherapy Blue and cover with gauze island dressing every evening shift until 7/23/21 or as needed. 6/17/21- Sacrum: cleanse with normal saline, pat dry, paint thin with skin prep, apply Alginate and cover with gauze island dressing every evening shift unit 7/11/21 and every 12 hours as needed for spoilage. 6/22/21- Left posterior heel: cleanse with normal saline, pat dry, the apply Silver Alginate with Silver and cover with dry dressing every evening shift.		patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	The 6/2021 Treatment Administration Records indicated the following: Left posterior heel, right medial heel, right lateral ankle, and sacrum treatments were last signed out as completed on 6/25/21. When interviewed on 6/28/21 at 12:00 p.m. regarding the wound care treatments not completed for several days as ordered by the Physician, the Corporate Nurse had no new information to add. This Federal tag relates to Complaint IN00354167. 3.1-40(a)(2)			