PRINTED: 09/09/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155218	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/26/2021	
NAME OF PROVIDER OR SUPPLIER GREAT LAKES HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2300 GREAT LAKES DR DYER, IN 46311				
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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)	JLD BE COMPLET	
Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00358517 completed on 7/27/21 Complaint IN00358517 - Not corrected. Survey date: 8/26/21 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Census Bed Type: SNF/NF: 85 Total: 85 Census Payor Type: Medicare: 1 Medicaid: 74 Other: 10 Total: 85 This deficiency reflects 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 July 25th-27th 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.		
F 0839 SS=E Bldg. 00	full-time, part-time professionals nece provisions of these	s ualifications. facility must employ on a or consultant basis those essary to carry out the e requirements. essional staff must be					

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

(X6) DATE

TITLE

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: R69H12 Facility ID: 000123 If continuation sheet Page 1 of 4

PRINTED: 09/09/2021 FORM APPROVED 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		00	COMPLETED	
	155218		B. W	ING		08/26/2021	
NAME OF F	DOMINED OD GUDDUTED	,		STREET.	ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF PROVIDER OR SUPPLIER					REAT LAKES DR		
GREAT L	AKES HEALTHCA	RE CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		-	TAG	DEFICIENCY)	DATE	
	accordance with a	applicable State laws.	F 0	920	PLAN OF CORRECTION	08/27/2021	
	Based on record review and interview, the facility		FU	839	Provider/Supplier Name:	08/2//2021	
		aff member who was			Great Lakes Healthcare Cen	ter	
	administering medications to residents was				Street Address, City, Zip:		
	_	ana Department of Health			2300 Great Lakes Drive		
	(IDOH) to pass med	dications (QMA certification).			Dyer, Indiana 46311		
		ial to affect 24 residents who			Date of Survey:		
		er hallway on the West Unit.			08/26/2021 Exit		
	(Employee 1)				PROVIDER/SUPPLIER/CLIA		
					IDENTIFICATION NUMBER		
	Finding includes:				ID PREFIX TAG		
	Employee licenses and certifications were				PROVIDER'S PLAN OF		
	reviewed on 8/26/21 at 3 p.m. Employee 1's start				CORRECTION: (EACH		
	date was 8/19/21 and was listed as a QMA. There				CORRECTIVE ACTION SHOU		
	was an out of state CNA verification certificate for				BE CROSS-REFERENCED T	0	
	Employee 1 along with a CNA/QMA testing				THE APPROPRIATE		
	request to a Community College for the State of				DEFICIENCY)		
	Indiana certification. A QMA Certification was not presented with the other certifications.				Preparation and/or execution	of	
	not presented with the other certifications.				this plan does not constitute		
	During an interview on 8/26/21 at 4:05 p.m., the				admission or agreement by th	e	
	West Unit Manager indicated Employee 1				provider that a deficiency exis		
	oriented with her on 8/24/21, administered				This response is also not to b		
	medications to residents on the center hall on the				construed as an admission of	fault	
	evening shift of August 25, 2021, and had				by the facility, its employees,		
	administered medications on 8/26/21 on the day				agents or other individuals wh		
	shift.				draft or may be discussed in t		
	D :				response and plan of correction	on.	
	During an interview on 8/26/21 at 4:10 p.m., the				This plan of correction is	liblo	
	West Unit Manager indicated there were 24 residents on the center hall who would have				submitted as the facility's cred	HIDIE	
	received medications from Employee 1.				allegation of compliance.		
	10001700 medications from Employee 1.				Please accept this plan of		
	On 8/26/21 at 4:30 p.m., a "Certificate of				correction as the provider's		
	Completion", dated 4/14/2011, was presented by				credible allegation of		
	the Scheduling Coordinator, which indicated				compliance. The facility wou	ıld	
	Employee 1 had successfully completed a				like to request a desk review		
"Trained Medication Administration for					for this survey.		

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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 COMPLETED 00 B. WING 08/26/2021 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 Unlicensed Personnel" course, which consisted of 48 contact hours, in another state. No certification was completed for Indiana. F 839 This deficiency was cited on 7/7/21. The facility SS-E failed to implement a systemic plan of correction Staff Qualifications 483.70(f)(1) to prevent recurrence. The facility will ensure staff This Federal tag relates to Complaint IN00358517. members who provide care to residents are certified/licensed 3.1-14(s)to do so The 24 residents who had the potential to be affected were not harmed The facility will identify other situations having the potential to be affected by the same deficient practices as follows: All licensed staff certification/license have been validated and are current to work in the state of Indiana What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur. Human Resource Director who failed to ensure a CMT certification was active in the state of Indiana no longer works for Great Lakes Healthcare Center Regional HRM will educate ED, DON and new HRM on ensuring all licensed staff

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

Event ID:

R69H12

Facility ID: 000123

certification/license have been validated to verify they are approved to work in the state of

If continuation sheet

Page 3 of 4

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

PRINTED: 09/09/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/26/2021	
NAME OF PROVIDER OR SUPPLIER GREAT LAKES HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2300 GREAT LAKES DR DYER, IN 46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI TAG DEFICIENCY)		TE	(X5) COMPLETION DATE	
					Indiana prior to orientation How the facility plans to monitor it performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved a sustained. This plan must be implemented, and the corrective action evaluated fits effectiveness. The plan of correction is integrated into quality assurance system. The ED or designee will complete an audit of all new helicense and registry prior to orientation for 90 days. The ED or designee will report to the QAPI Committee monthly findings from the wee audits. This process will be monitored by the Director of Nursing Services, Administrate and Medical Director. The QA committee will determine when 100% compliance is achieved if further monitoring is required.	nd e for of the l ires l kly or API n and	

Event ID: R69H12 Facility ID: 000123 If continuation sheet Page 4 of 4