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	08/26/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 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. Quality review completed on 8/31/21.	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	483.70(f)(1)(2) Staff Qualifications §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in			

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

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	accordance with applicable State laws. Based on record review and interview, the facility failed to ensure a staff member who was administering medications to residents was certified by the Indiana Department of Health (IDOH) to pass medications (QMA certification). This had the potential to affect 24 residents who resided on the center hallway on the West Unit. (Employee 1) Finding includes: Employee licenses and certifications were reviewed on 8/26/21 at 3 p.m. Employee 1's start date was 8/19/21 and was listed as a QMA. There was an out of state CNA verification certificate for Employee 1 along with a CNA/QMA testing request to a Community College for the State of Indiana certification. A QMA Certification was not presented with the other certifications. During an interview on 8/26/21 at 4:05 p.m., the West Unit Manager indicated Employee 1 oriented with her on 8/24/21, administered medications to residents on the center hall on the evening shift of August 25, 2021, and had administered medications on 8/26/21 on the day shift. During an interview on 8/26/21 at 4:10 p.m., the West Unit Manager indicated there were 24 residents on the center hall who would have received medications from Employee 1. On 8/26/21 at 4:30 p.m., a "Certificate of Completion", dated 4/14/2011, was presented by the Scheduling Coordinator, which indicated Employee 1 had successfully completed a "Trained Medication Administration for	F 0839	**PLAN OF CORRECTION** **Provider/Supplier Name:** **Great Lakes Healthcare Center** **Street Address, City, Zip:** **2300 Great Lakes Drive** **Dyer, Indiana 46311** **Date of Survey:** **08/26/2021 Exit** **PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER** **ID PREFIX TAG** **PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)** Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. **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.**	08/27/2021

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	Unlicensed Personnel" course, which consisted of 48 contact hours, in another state. No certification was completed for Indiana. This deficiency was cited on 7/7/21. The facility failed to implement a systemic plan of correction to prevent recurrence. This Federal tag relates to Complaint IN00358517. 3.1-14(s)		**F 839** **SS – E** **Staff Qualifications 483.70(f)(1)(2)** **The facility will ensure staff members who provide care to residents are certified/licensed 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 certification/license have been validated to verify they are approved to work in the state of	

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			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 and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system**. · The ED or designee will complete an audit of all new hires license and registry prior to orientation for 90 days. · The ED or designee will report to the QAPI Committee monthly findings from the weekly audits. This process will be monitored by the Director of Nursing Services, Administrator and Medical Director. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required.	