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	09/18/2024

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 the Investigation of Complaints IN00441666 and IN00442817. Complaint IN00441666 - No deficiencies related to the allegations are cited. Complaint IN00442817 - Federal/State deficiencies related to the allegations are cited at F609 and F740 Unrelated deficiencies are cited. Survey dates: September 17 & 18, 2024 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Census Bed Type: SNF/NF: 108 Total: 108 Census Payor Type: Medicare: 3 Medicaid: 72 Other: 33 Total: 108 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/23/24.	F 0000	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 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on record review and interview, the facility	F 0609	**609**	10/19/2024

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

Jason Eastlund | Executive Director | 10/11/2024

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	failed to accurately and thoroughly report an allegation of resident to resident abuse to the Indiana Department of health (IDOH), related to location of altercation, circumstances of the altercation, diagnoses of the residents, injury, and results of the investigation in the five day follow-up, for 1 of 2 abuse incidents reviewed. (Residents C and D) Findings include: An IDOH reported incident, dated 9/2/24 with a follow-up date of 9/6/24, indicated Residents C and D had a physical altercation that resulted in Resident C falling to the ground and Resident D receiving a scratch to his left eye. The diagnosis listed for Resident C was bi-polar disorder. The injury of the incident indicated Resident C had a hematoma (bruise) to the back of his head and Resident D had a scratch under his eye. Resident C refused treatment and Resident D was transferred to the Emergency Room for an evaluation and treatment as needed. The follow-up, dated 9/6/24, indicated there were no further issues noted between the residents, they remained at baseline during the Social Service and Psychiatric follow-up, and the care plans were updated to reflect current needs. A) Resident C's record was reviewed on 9/17/24 at 1 p.m. The diagnoses included, but were not limited to, alcohol dependency. There was no diagnosis of bi-polar. A Nurse's Progress Note, dated 9/2/24 at 3:30 a.m., indicated there had been an altercation outside		1 ED/Designee reviewed SRI #544 to ensure all appropriate documentation were in the file to indicate an accurate depiction of the resident to resident event. Resident C no longer resides in the facility. Resident D has no psychosocial effects from the SRI. ED/Designee completed a 2 week look back on all SRI to ensure Accuracy was depicted to ISDH. ED/Designee re-educated on F tag 609 by the RDO, prior to date of compliance. RDO/Designee will audit all SRI, for 12 weeks, prior to sending to ISDH, to ensure accuracy and thorough representation of events.	

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	between the resident and another male resident. The resident had a hematoma to the left eyebrow and he aggressively refused emergency care. An Interdisciplinary Team (IDT) Progress Note, dated 9/3/24 at 12:52 p.m., indicated a fall had occurred on 9/2/24 related to an altercation with another resident. The root cause was intoxication. A Social Services Progress Note, dated 9/3/24 at 3:32 p.m. and signed by the Administrator, indicated the resident was interviewed and had no recollection of the incident. He acknowledged he drank alcohol that he had obtained from the liquor store while out on pass. The reported incident had not included the altercation occurred outside of the building at 3:30 a.m., Resident C was intoxicated, and the injury was not a hematoma to the back of the head. The injury was a hematoma/bruising to the left eye/brow. A Witness Statement from Resident L indicated Resident C was yelling at Resident D. Resident C stood up and swung at Resident D. Resident D stepped out of the way and Resident C fell to the ground. There had been no physical contact. A statement from Resident D indicated Resident C stood up and swung at him, he stepped out of the way and Resident C fell to the ground. His face came in contact with the concrete. Resident D entered the building and reported the incident to the nurse. B) During an interview on 9/17/24 at 9:24 a.m., Resident D indicated Resident C had been cussing him out and they had not had any problems prior to this night. Resident D then			

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	refused to answer any other questions. Resident D's record was reviewed on 9/17/24 at 4:45 p.m. The diagnoses included, but were not limited to, bi-polar and schizophrenia. An Annual Minimum Data Set assessment, dated 7/7/24, indicated an intact cognition and was independent for all activities of daily living. A Nurse's Progress Note, dated 9/2/24 at 3:50 a.m., indicated an altercation with another resident occurred outside the building. It was unclear of the events that had taken place prior to the altercation. The resident was transferred to the hospital for an evaluation. A Nurse's Progress Note, dated 9/2/24 at 5:35 a.m., indicated the resident returned to the facility with no new physician's orders. A Social Service Progress Note, dated 9/4/24 at 3:12 p.m., indicated Resident C was upset with Resident D for talking. Resident C stood up and attempted to hit Resident D. Resident D then stepped out of the way and Resident C fell to the ground and hit his face. Resident D indicated he was not mad or upset and denied having any issues with Resident C. The follow-up report to the IDOH had not included what the investigation concluded for the cause of the altercation and the what had actually occurred during the incident. During an interview on 9/17/24, the Administrator indicated both residents smoked independently and the incident occurred in the smoking area. There were no set times for smoking for the independent residents. The times have been			

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	changed to 6 a.m. to 10 p.m. since the incident. During an interview on 9/18/24 at 9:15 a.m., the Director of Nursing indicated they were initially informed there had been physical contact and it was verified with the investigation that there was no physical contact. She indicated Resident D had been transferred to the Emergency Room for precautionary measures. The Administrator indicated the incident occurred at 3 a.m. and that is when the first report went to the IDOH. He indicated the follow-up report had not included the investigation summary or the clarification of injuries. The follow up had not included that no physical contact had been made. An undated abuse policy, received from the Administrator as current on 9/17/24 at 2:06 p.m., indicated the initial incident report to the IDOH must provide sufficient information to describe the alleged violation. The results of the facility's investigation must be reported to the IDOH within five working days of the incident. This citation relates to Complaint IN00442817. 3.1-28(c)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on record review and interview, the facility failed to have a current smoking assessment completed for 1 of 3 residents reviewed who smoked independently. (Resident C) Finding includes: Resident C's record was reviewed on 9/17/24 at 1 p.m. The diagnoses included, but were not limited	F 0689	**689** 1 Resident C no longer resides in the facility. 2 ED/Designee completed 100% audit of all smoking residents to ensure quarterly audits are completed. 3 ED/Designee educated MDS and SS department on quarterly	10/19/2024

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	to, alcohol dependency. The most current smoking assessment was completed on 9/20/23 at 4 a.m. and indicated the resident was assessed to smoke independently. During an interview on 9/17/24 at 2:56 a.m., Social Service 1 indicated there had not been a current smoking assessment completed. An undated resident smoking policy, received as current from the Director of Nursing on 9/17/24 at 2:06 p.m., indicated the residents would be assessed by the interdisciplinary team for smoking assistance status upon admission, quarterly, and with a significant change of condition. 3.1-45(a)		and significant change smoking assessment requirements 4 ED/Designee will audit 5 smoking residents per week for 12 weeks, to ensure quarterly assessments are completed	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services Based on record review and interview, the facility failed to monitor a resident with a history of substance abuse for signs and symptoms of alcohol use and the resident had an altercation with another resident while intoxicated, for 1 of 2 residents reviewed for behaviors. (Resident C) Finding includes: Resident C's record was reviewed on 9/17/24 at 1 p.m. The diagnoses included, but were not limited to, alcohol dependency. A Nurse's Progress Note, dated 5/6/24 at 9:11 a.m., indicated the resident signed out of the facility on a pass.	F 0740	740 1 Resident C no longer resides in facility. Resident D had social services assessment and no psychosocial issues related to the incident. 2 ED/Designee completed 100% assessment of all residents on behavior monitoring contracts to ensure appropriate plan and care plan were in place. 3 ED/Designee educated all licensed nurses and SS	10/19/2024

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	A Nurse's Progress Note, dated 5/6/24 at 4:51 p.m., indicated a nearby store employee observed the resident to be slumbering and he appeared to be intoxicated. The employee notified Emergency Management Services (EMS) and the resident was transferred to the hospital. A Nurse's Progress Note, dated 5/6/24 at 7:46 p.m., indicated a report from the hospital was received. The blood alcohol was measured at 108 (over 50 = intoxicated) and a bottle of vodka had been confiscated from the resident. He was administered a liter of normal saline intravenous fluid and had returned to the facility with no distress or discomfort. A Interdisciplinary Team Note, dated 5/9/24 at 11:02 a.m., indicated the resident fell while out on pass on 5/8/24 (sic). He was observed by a store employee to be intoxicated. Education about drinking alcohol to excess while out of the facility, safety related to drinking alcohol and risks was completed. The resident indicated he would stop drinking. A Behavioral Contract related to drinking alcohol excessively was signed by the resident. A Nurse Practitioner's Progress Note, dated 5/9/24 at 9:48 a.m., indicated the resident was alert and oriented. The resident was intoxicated at a store near the facility and had fallen, was taken to the Emergency Room, and was diagnosed with a left thumb fracture. A Care Plan, revised on 5/9/24, indicated a risk for falls and a fall had occurred on 5/6/24. The intervention added on 5/9/24, indicated education would be given related to safety and risk when drinking to excess while out of the facility.		department on behavior monitoring policy and procedure when residents are on behavior contracts. ED/Designee will audit 5 random residents weekly X 12 weeks regarding behavior monitoring being in place. ED/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 95% compliance achieved	

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	A Social Service Note, dated 5/10/24 at 3:02 p.m. and written by the Administrator, indicated the Behavioral Contract had been reviewed with the resident. There was a moderately impaired cognitive status. The resident verbalized understanding of the contract and his rights and was agreeable to follow the guidelines. He was offered a 12-step program and he declined. He was given the Administrator's cell phone number and encouraged to notify him if any assistance was wanted. The Guideline for Resident Behavior (Behavior Contract) was signed on 5/10/24 by the resident indicated, "...possession of or use of alcohol must be authorized by the facility..." Non-compliance with the Behavior Contract indicated a behavioral management plan would be developed. There were no care plans or behavior management plan for the alcohol abuse initiated after the incident of 5/6/14 and after the Behavioral Contract was signed. There was no behavioral plan that indicated the resident would be monitored for alcohol usage and behaviors related to alcohol usage after the Behavioral Contract was signed. A Quarterly Minimum Data Set assessment, dated 8/8/24, indicated a severely impaired cognitive status and verbal behaviors occurred one to three days during the assessment period. A Physician's Progress Note, dated 8/23/23 at 12:53 p.m., indicated an orientation times three (person, place, and time). There was no documentation that indicated the resident was monitored for alcohol usage and			

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	behaviors from 5/6/24 through 9/2/24. A Nurse's Progress Note, dated 9/2/24 at 3:30 a.m., indicated there had been an altercation outside between the resident and another male resident. The resident had a hematoma to the left eyebrow and he aggressively refused emergency care. A Nurse Practitioner's Progress Note, dated 9/3/24 at 10:58 a.m., indicated an altercation with another resident had occurred on 9/2/24 and resulted in bruising of the left eye and hematoma of the left brow area. The resident was not sure if he was pushed down or not. He was alert and oriented times three, pleasant, cooperative and answered questions appropriately. A Social Service Note, dated 9/3/24 at 11:31 a.m. and signed by Social Service (SS) 1, indicated education on the smoking policies and behavior policies and Social Service will assist as needed. An Interdisciplinary Team Progress Note, dated 9/3/24 at 12:52 p.m., indicated a fall had occurred on 9/2/24 related to an altercation with another resident. The root cause was intoxication. A Social Services Progress Note, dated 9/3/24 at 3:32 p.m. and signed by the Administrator, indicated the resident was interviewed and had no recollection of the incident. He acknowledged he drank alcohol that he had obtained from the liquor store while out on pass. A Psychiatry Progress Note, dated 9/3/24 and no time documented, signed on 9/4/24 at 1:50 p.m., indicated a history of alcohol dependency. The resident had an altercation with another resident and had allegedly calling the other resident rude/derogatory names. He attempted to hit the			

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	other resident and the other resident then hit him and it resulted in a black eye. The resident (Resident C) was intoxicated. The resident refused a change in medication. Severe impairment of judgement, oriented to person and place, fair long and short term memory. The nursing staff were to monitor and document any new or worsening moods/behaviors There were no behavioral plans/care plans for the alcohol consumption and monitoring initiated. The Director of Nursing (DON) provided several sheets of small papers on 9/17/24, that indicated the resident had signed himself out of the facility frequently from May to August 30, 2024. The Resident Sign Out forms, indicated he had signed himself out on the following dates and times in September: On 9/1/24 at 4:50 p.m. to 5:07 p.m., no reason documented. On 9/2/24 at 9:20 a.m. to 9:30 a.m. and went to the store,10:25 a.m. to 11 a.m. to sit out front and smoke, and 1:10 p.m. to 1:30 p.m. to sit outside to smoke. On 9/4/24 at 12:30 p.m. through 12:40 p.m. to go to the store. On 9/5/24 at 6:15 p.m. to 6:30 p.m. to go to the store. On 9/6/24 at 5:21 p.m.., no time signed as return, to go to the store. On 9/8/24 at 12:00 p.m. to 12:15 p.m., to go to the store. On 9/10/24, no time documented, to go to the store. On 9/11/24, no time documented, to go to the store. On 9/12/24 at 6:20 (no a.m. or p.m.) to 6:45 to go to the store.			

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	During an interview on 9/17/24 at 2:47 p.m., the Administrator indicated the behavior monitoring plan was that the staff were allowed to check the resident for alcohol. The Behavior Contract had not indicated the facility had to assess the resident every time he left on pass and returned. The Behavior Contract did not say the staff would assess him for alcohol consumption and it did say they could search his room. The residents cognitive status fluctuated. During an interview on 9/17/24 at 2:56 p.m., SS 1 indicated there was no care plan for the alcohol use and the behavior of alcohol consumption. During an interview on 9/17/24 at 4:50 p.m., the Director of Nursing indicated there were no behavior monitoring records for the resident. An undated behavioral management policy, received from the Director of Nursing as current on 9/18/24 at 2:01 p.m., indicated residents would be provided with a resident centered behavior management plan to safely manage the resident and others. The resident would be assessed for problematic/dangerous behaviors. The behavior would be documented in the medical record. The Care Plan would be updated with changes and/or new behaviors. This citation relates to Complaint IN00442817. 3.1-37(a)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to ensure a resident's record was complete	F 0842	**842** 1 Resident J was interviewed	10/19/2024

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	and accurate related to an intrafacility transfer for 1 of 9 residents reviewed for medical record accuracy. (Resident J) Finding includes: Resident J's record was reviewed on 9/18/24 at 11:41 a.m. The diagnoses included, but were not limited to, paraplegia. An Annual Minimum Data Set assessment, dated 7/17/24, indicated an intact cognitive status A Notification of Room Change form, dated 8/8/24 at 12:00 a.m., indicated a transfer from one room to another. The reason for the room transfer was listed as long term bed, the resident was satisfied with room change and the new roommate. The form was not signed by the resident. The instructions at the bottom of the form indicated signatures were to be obtained and the form was to be uploaded into the electronic health record. During an interview on 9/18/24 at 11:50 a.m., Social Service 1 indicated the resident was not happy about the intrafacility transfer. There was no documentation the resident had been given prior notice of an impending intrafacility transfer, the option of choosing the room and roommate, and the actual date and time of the transfer. During an interview on 9/18/24 at 12 p.m., the Administrator indicated the resident had been given plenty of notice and she had chosen the room she transferred to herself. The resident had been in a private room and was informed she would need to have a roommate.		by SS and acknowledged that she was notified and in agreement with room transfer, prior to it occurring. 2 ED/Designee completed a 2 week lookback on all intra-facility transfers to ensure appropriate notification and documentation was completed prior to room move 3 ED/Designee educate SS department on policy and procedure for intra-facility transfers, prior to date of compliance. 4 ED/Designee will audit all intra-facility transfers for 12 weeks to ensure adequate notice and paperwork signed related to intra-facility transfers.	

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	During an interview on 9/18/24 at 12:25 p.m., the Administrator indicated he had spoken to the resident personally and she was in agreement with the room transfer. He indicated the conversation should have been documented and acknowledged there had been no documentation in the record. 3.1-50(a)(1) 3.1-50(a)(2)			