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	11/18/2021

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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 IN00364158, IN00365837, IN00365839, IN00365910 and IN00366713. Complaint IN00364158 - Substantiated. Federal/State deficiencies related to the allegations are cited at F695 and F880. Complaint IN00365837 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00365839 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00365910- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00366713- Substantiated. No deficiencies related to the allegations are cited. Survey dates: November 17 and 18, 2021 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Census Bed Type: SNF/NF: 89 Total: 89 Census Payor Type: Medicare: 7 Medicaid: 69 Other: 13 Total: 89 These deficiencies reflect State Findings cited in	F 0000	The Plan of Correction is the center's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. The facility respectfully requests a desk review for this plan of correction.	

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

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	accordance with 410 IAC 16.2-3.1. Quality review completed on 11/22/21.			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure tracheostomy supplies including 2 tracheostomy tubes, were available for immediate use and suctioning was performed in a sanitary way for 1 of 3 residents reviewed for tracheostomy care. (Residents E) Finding includes: On 11/17/21 at 1:45 p.m., Resident B was observed in bed with a tracheostomy tube intact and a person from the therapy department at her bedside. At that time, the resident was in respiratory distress and indicating to the therapist she needed to be suctioned. The therapist left the room and the resident was attempting to sit on the side of the bed. After sitting up, she picked up a cup and started to spit out phlegm from her mouth. LPN 1 entered the room and washed her hands with soap and water. She was wearing a regular face mask and a face shield over her face. She started to look in the	F 0695	**1) Resident B was not harmed by the alleged deficient practice. A tracheostomy of the same size and a tracheostomy one size smaller was placed in resident's room with other necessary equipment for immediate use as needed. Upon notification of suctioning technique the physician and family were made aware and the nurse was provided education on tracheostomy suctioning and a competency was completed.** **2) All other residents that have tracheostomies have the potential to be affected. An audit was conducted on all residents with tracheostomy's to ensure that there was the appropriate tracheostomy equipment. Anyone found**	12/09/2021

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	resident's nightstand drawers and removed a suction kit. She opened it up, donned gloves to both hands, and looked again in the top nightstand drawer. She removed her gloves and left the room. The resident continued to have distress but was now lying in the bed with her head elevated and eyes closed. The resident had a trach oxygen mask over her tracheostomy. The oxygen flow rate was set at 5 liters. There was 1 spare trach size 4 in a box, a box of disposable inner cannulas, and 1 trach cleaning kit observed across from the resident, on the dresser, back in a corner, under the television set. There was a used yanker (suction piece) in an opened package in between the suction machine and the oxygen humidification machine. There were no other clean yankers to suction the resident's mouth anywhere in the room. The nurse returned with 4 bottles of normal saline and removed another suction kit from the drawer and donned the gloves to both hands. She suctioned the resident's tracheostomy and the resident immediately sat up and indicated she could not breathe. LPN 1 told her to try and relax and settle down. She suctioned again and the resident sat on the side of the bed and again said she could not breathe. LPN 1 said "let me suction your mouth." The resident agreed and the LPN using the same suction tubing as she did with the tracheostomy, suctioned the resident's mouth. She let the resident rest a minute and indicated to her she was going to change her inner cannula. The LPN removed the inner cannula and took another from the box and placed it into the resident's trachea tube. LPN 1 suctioned the resident's mouth again and then using the same suction tubing, suctioned the resident's tracheostomy. The resident indicated she was better and wanted to sit up for a while. The LPN removed her gloves and washed her hands with		**without needed equipment had the tracheostomy equipment placed in the room immediately.** **3) The Regional Respiratory Therapist manager educated all licensed nurses on tracheostomy suctioning, set-up with emphasis on additional emergency equipment at bedside, and a return demonstration competency was completed on each licensed nurse.** **4) The DON/Designee will audit all residents identified with a tracheostomy rooms for needed equipment 3 x weekly for 4 weeks, then 2 times weekly for 4 weeks, then 1 x weekly for 4 weeks.** **The DON/Designee will audit via observation 3 licensed nurses perform suctioning on a tracheostomy patient 3 x weekly for 4 weeks, 2 times weekly for 4 weeks, and 1 x weekly for 4 weeks.** **5) The Director of Nursing or Designee will report to the QAPI committee findings and the QA committee will determine when compliance is achieved or if ongoing monitoring is required.**	

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	soap and water and left the room to get a CNA to sit with the resident. Interview with the LPN 1 at that time, indicated she was aware she had suctioned the resident's mouth with the same suction tubing and then suctioned the tracheostomy again with the same tubing. The LPN insisted it was an emergency so "I did what I had to do in the moment." However, there was no normal saline to suction the resident in the room and she had only an used a yanker. The room was cluttered with tracheostomy supplies every where and it was hard to find the items she needed and there were supplies that were not available for use. On 11/17/21 at 3:30 p.m., the resident was observed sitting on the side of the bed in no respiratory distress. She was alert and oriented and talking with her family. Her oxygen was set at a rate 5 liters per minute. There was still only 1 spare tracheostomy in the room. Interview with the resident at that time, indicated they do not change her inner cannula on a daily basis since she had been there. Interview with LPN 1 on 11/17/21 at 3:40 p.m., indicated she was unaware what size trach was in the room and if there was more than one. She was also unaware what the oxygen flow rate was supposed to be set on. The LPN 1 walked into the resident's room and indicated the oxygen was set at 5 liters. The LPN indicated the concentrator only goes up to 5 liters, but they had a different one and she would replace it now. There was no other spare tracheostomy in the room besides the #4. There has been inservice training on tracheostomy care in the past but a long time ago. LPN 1 had been taking care of the			

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	resident all day. Interview with LPN 2 on 11/17/21 at 3:45 p.m., indicated she had taken care of the resident for the last couple of days on the evening shift and gave her a breathing treatment last night. She indicated she was not that familiar with "trachs" and if she needed help she would get another nurse to help her. LPN 2 stated, "I did not look at the resident's oxygen concentrator yesterday evening when I was in the room. It was a busy night." The LPN indicated she would like inservice training because it had been a long time since she has worked with "trachs." The resident wanted her inner cannula changed yesterday evening, but she just suctioned her and did not change it because she was not familiar on how to do that. The record for Resident E was reviewed on 11/17/21 at 2:45 p.m. The resident was admitted to the facility on 11/14/21. Diagnoses included, but were not limited to, heart failure, high blood pressure, chronic respiratory status, tracheostomy, and anxiety. Physician's Orders, dated 11/14/21, indicated trach care, with sterile lubrication. Inspection of inner cannula - change or clean daily and as needed. Lavage with normal saline for thick secretions. Change trach dressing and trach ties as needed. Suction for increased secretions. Provide manual inflation of lungs prior to suctioning patient's trach using ambu bag (Deep Bag Inflation). Trach, Ambu bag, oxygen (e.g., E-Cylinder), suction canister and catheters in room at all times. Trach type and size #4 and one smaller/type trach, obturator, lubrication kit, and large syringe for cuff inflation at bedside at all times. 6 litters of oxygen via trach continuously.			

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Physician's Orders, dated 11/16/21, indicated full PPE (Personal Protective Equipment) donning, which includes the N-95 mask with trach care.

The Care Plan, dated 11/15/21, indicated the resident had an alteration in respiratory status related to chronic respiratory failure. A nursing approach was to provide oxygen therapy as ordered.

The Care Plan, dated 11/16/21, indicated the resident was currently receiving tracheostomy care. A nursing approach was to keep extra trach(s) at bedside, current size and one size smaller.

Interview with the Director of Nursing (DON) on 11/18/21 at 9:00 a.m., indicated she set up all the trachs and all the trach equipment. She indicated inside the top drawer of the resident's night stand there should have been all the supplies including saline, suctioning kits, the spare trach, and the yankers for suctioning. Training for 90% of the nurses was completed by the Corporate Respiratory Therapist Consultant in August 2021 when they had 2 trach residents. LPN 2 was not part of that training. When new trach residents were admitted to the facility, the contracted respiratory therapy company who supplied the oxygen for the facility would come in and make sure the oxygen was set up correctly. At this time, the respiratory therapy company had not been out yet to evaluate the oxygen situation for Resident E.

Continued interview with the DON on 11/18/21 at 11:00 a.m., indicated the inservice training for tracheostomy care was provided by the

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	Corporate Respiratory Therapist on 8/6/21 and only 10 nurses were inserviced/trained on trach care. The content was tracheostomy care, suctioning, ties, holders, set up, point click care batch orders. LPN 1 and LPN 2 did not participate in the training. This Federal tag relates to Complaint IN00364158. 3.1-47(a)(6)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies,			

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	and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to not using the appropriate personal protective equipment (ppe) during tracheostomy care and suctioning and the placement of wound treatment materials in a resident's bed for 1 of 1 observations of tracheostomy care and 1 of 1 observations of wound care. (Residents E and K) Findings include: 1. On 11/17/21 at 1:45 p.m., Resident B was observed in bed with a tracheostomy, and a person from the therapy department was at her bedside. At that time the resident was in respiratory distress and indicating to the therapist she needed to be suctioned. The therapist left the room and the resident was attempting to sit on the side of the bed. After sitting up, she picked up a cup and started to spit out phlegm from her mouth. LPN 1 entered the room and washed her hands with soap and water. She was wearing a regular face mask and a face shield over her face. She started to look in the resident's nightstand drawers and removed a suction kit. She opened it up, donned gloves to both hands, and looked again in the top nightstand drawer. She removed her gloves and left the room. The resident continued to have distress but was now laying in the bed with her head elevated and eyes closed. The nurse returned with 4 bottles of normal saline and removed another suction kit from the drawer and	F 0880	**F 880** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** LPN 1 was educated on proper procedure for tracheostomy care and the use of N95 when caring for tracheostomy patients. Wound nurse was educated on infection control practices regarding wound care, including, but not limited to dressing changes **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice. The DON or designee will complete the following: · Staff involved will educated in infection control practices regarding wound care, including, but not limited to dressing changes. o Competency: Wound Dressing Change	12/09/2021

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	donned the gloves to both hands. She suctioned the resident's tracheostomy and the resident immediately sat up and indicated she could not breathe. LPN 1 told her to try and relax and settle down. She suctioned again and the resident sat on the side of the bed and again said she could not breathe. LPN 1 said "let me suction your mouth." The resident agreed and the LPN using the same suction tubing as she did with the tracheostomy, suctioned the resident's mouth. She let the resident rest a minute and indicated to her she was going to change her inner cannula. The LPN removed the inner cannula and took another from the box and placed it into the resident's trachea tube. LPN 1 suctioned the resident's mouth again and then using the same suction tubing, suctioned the resident's tracheostomy. The resident indicated she was better and wanted to sit up for awhile. The LPN performed the entire procedure while only wearing a surgical face mask. There was no ppe outside of the resident's room or nearby. The record for Resident E was reviewed on 11/17/21 at 2:45 p.m. The resident was admitted to the facility on 11/14/21. Diagnoses included, but were not limited to, heart failure, high blood pressure, chronic respiratory status, tracheostomy, and anxiety. Physician's Orders, dated 11/16/21, indicated full PPE (Personal Protective Equipment) donning, which includes the N-95 mask with trach care. Interview with the Director of Nursing on 11/18/21 at 9:00 a.m., indicated the nurses were to be wearing an N95 face mask when suctioning the resident.2. On 11/18/21 at 9:05 a.m., Resident K's wound care was observed with the		· Staff will be educated on the correct procedure for tracheostomy care o Policy: Use of PPE while in the facility o Policy: PPE guidance for aerosol generating procedures ·Policy: Tracheostomy Suctioning **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** A Root Cause Analysis (RCA) was conducted with the Infection Preventionist (IP) and input from the IDT and the facility Medical Director/IP/DON. The root cause was identified resulting in the facility's failure. Solutions were developed and systemic changes were identified that need to be taken to address the root cause. The Infection Preventionist and IDT reviewed the LTC infection control self-assessment and identified changes to make accurate **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:**	

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	Wound Care Nurse. The nurse indicated she would change the dressing on the right side abdominal fold first, then do the dressing to his left axilla. The nurse placed two open foam dressings and a tube of clobetasol cream (a medication used to treat skin conditions) on a Styrofoam tray and placed it on the bed. She then placed three pair of disposable gloves, two open packages of calcium alginate (wound dressing material) and a black marker directly on the resident's bed. The nurse removed the calcium alginate from an open package and applied clobetasol cream onto it, she then placed the cream directly on the bed. She went to her treatment cart and retrieved two open packages of gauze that were soaking in normal saline and placed the packages directly on the bed. She removed the gauze from the open package, cleansed the resident's wound and applied the dressing. She then moved to the resident's right side. She retrieved a box of gloves and a bottle of hand sanitizer and placed them directly on the bed. She cleansed the wound with the gauze and applied the dressing. The resident record was reviewed on 11/18/21 at 10:04. The resident was admitted on 1/8/21. Diagnoses included, but were not limited to, Diabetes Mellitus and chronic obstructive pulmonary disease. A Physician's order, dated 10/19/21, indicated to cleanse left axilla and right chest area with normal saline and pat dry, apply clobetasol cream and calcium alginate, then cover with a foam dressing daily. Interview with the Wound Care Nurse after the wound treatments, indicated she understood the bed was not a clean surface.		After the IDT and Infection Preventionist completed the RCA and LTC infection control assessment, training identified above was implemented to facility staff. The training will be conducted by the DON, IP or Medical Director with documentation of completion. To ensure Infection Control Practices are maintained, the following monitoring will be implemented. 1. The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA and as noted above, daily or more often as necessary for 6 weeks and until compliance is maintained. Ensure staff execute infection control practices regarding resident wound care – dressing changes Ensure staff execute correct procedure and wearing of N95 during trach care 2. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified as above. This will occur for 6 weeks and until	

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	Interview with the Director of Nursing on 11/18/21 at 9:27 a.m., she indicated treatments were to be prepared at her treatment cart and that items should not be set directly on the bed. This Federal tag relates to Complaint IN00364158. 3.1-18(a)		compliance is maintained. Ensure staff execute infection control practices regarding resident wound care – dressing changes Ensure staff execute correct procedure and wearing of N95 during trach care **Quality Assurance and Performance Improvement (QAPI):** The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	