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

FORM APPROVED
OMB NO. 0938-039

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	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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 IN00402339, IN00404402, IN00407169, IN00409022, IN00409253, IN00413262, IN00413351, IN00413483, and IN00413839. Complaint IN00402339 - No deficiencies related to the allegations are cited. Complaint IN00404402 - No deficiencies related to the allegations are cited. Complaint IN00407169 - Federal/State deficiencies related to the allegations are cited at F686. Complaint IN00409022 - No deficiencies related to the allegations are cited. Complaint IN00409253 - No deficiencies related to the allegations are cited. Complaint IN00413262 - Federal/State deficiencies related to the allegations are cited at F684 and F773. Complaint IN00413351 - Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00413483 - Federal/State deficiencies related to the allegations are cited at F759. Complaint IN00413839 - No deficiencies related to the allegations are cited. Survey dates: August 1, 2, and 3, 2023 Facility number: 000123 Provider number: 155218	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. Facility respectfully requests paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason E Eastlund	Executive Director	08/18/2023

Any defiencystatement 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 disclo days 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.

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	AIM number: 100267720 Census Bed Type: SNF/NF: 100 Total: 100 Census Payor Type: Medicare: 4 Medicaid: 88 Other: 8 Total: 100 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/4/23.			
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 ensure a change in condition related to edema was assessed and monitored, a fall follow up assessment and neurological checks were completed, and an assessment including vital signs was documented prior to hospitalization for 1 of 3 residents reviewed for falls and 2 of 3 residents reviewed for a change in condition. (Residents E and K) Findings include:	F 0684	1. Residents E and K were not harmed by the alleged deficient practice. Resident E no longer resides at the facility. Resident K returned from the hospital and has remained in stable condition. 2. All residents with a condition change related to edema, all residents with a	08/18/2023

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	1. The closed record for Resident E was reviewed on 8/1/23 at 2:00 p.m. Diagnoses included, but were not limited to, wedge compression fracture, paraplegia, uropathy, depressive disorders, urine retention, schizophrenia, history of falling, and anemia. The Annual Minimal Data Set (MDS) assessment, dated 6/15/23, indicated the resident was moderately impaired for decision making. The resident was an extensive assist with 1 person physical assist for bed mobility and toilet use. She needed supervision for transfers and was independent for locomotion off the unit. A Care Plan, revised on 6/16/23, indicated the resident was at risk for falls related to a decline in functional status, weakness, pain, paraplegia, and wedge compression fractures. Nurses' Notes, dated 5/11/23 at 4:54 p.m., indicated the resident was heard per staff calling out for help. Upon entering the resident's room, she was noted to be sitting on the floor next to the bed. The resident indicated she slid out of her wheelchair trying to get from the chair to the bed. The resident denied pain, hitting her head, and any discomfort. Her vital signs were blood pressure 136/90, pulse of 88, respirations were 18, and the temperature was 99.2. A post fall observation/assessment, dated 5/11/23 at 4:47 p.m., indicated the resident had an unwitnessed fall with no injuries. Neurological checks were initiated on 5/12 at 6:00 a.m., 5/12 at 10:00 a.m., and 5/12 at 2:00 p.m. There were no neurological checks initiated immediately after the fall on 5/11/23.		condition change resulting in hospitalization and all residents with a fall have the potential to be affected by same alleged deficient practice. All residents with an acute condition change for edema, over the last 14 days have been assessed to ensure a full assessment and follow up are complete. All current residents with an acute condition resulting in hospitalization, over the last 14 days, have been reviewed to ensure a full assessment with vital signs is present in the progress notes. All residents sustaining a fall over the last 14 days have been reviewed to ensure a thorough fall follow up assessment and neurological checks are in place, if appropriate. All audits were completed by the DON/Designee by 8/18/23. 3. DON/Designee has educated all licensed nurses on the Notification of Change in Condition policy with an emphasis on notifications and follow up. DON/Designee has educated all licensed nurses on the Fall Prevention and Management policy with an emphasis on fall follow up. All education completed by 8/18/23. DON/Designee will audit all residents with a change in condition related to edema and all	

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	There were no fall follow up assessments completed after the fall on 5/11/23. A Podiatrist physical exam, dated 6/9/23, indicated the resident had pitting plus edema to both feet. A Nurses' Note, dated 6/16/23 at 12:44 p.m., indicated the resident's POA (Power of Attorney) phoned in with medical concerns regarding the resident's condition. The Physician was notified and new orders were received for labs of a CBC (Complete Blood Count), a BMP (Basic Metabolic Panel) to be drawn on 6/19/23. The Physician also ordered x-rays of the lower back and bilateral knees. The medication of Lasix (a diuretic) 20 milligrams (mg) daily related to bilateral lower extremity swelling was also ordered. Physician's Orders, dated 6/16/23 indicated CBC, CMP, and Lasix 20 mg daily. Lumbar spine x-rays 2 views, a portable left and right knee x-ray with 2 views. A Nurses' Note, dated 6/16/23 at 12:45 p.m., indicated the resident had complaints of lower back pain and left and right knee pain. She was also noted with 2 plus edema to the bilateral lower extremities. The next documented Nurses' Note was dated 6/17/23 at 1:56 p.m., which indicated the x-rays were completed and the resident's feet remained swollen. A Nurses' Note, dated 6/18/23 at 10:46 a.m., indicated the resident had 3 plus bilateral edema noted to her feet. There was no more documentation or an		residents requiring a hospital transfer to ensure a full assessment and follow up are completed 3 X per week, in clinical meeting, for 4 weeks, then 3 residents 3 x wk x 8 weeks. DON/designee will audit all residents with a fall 3 X per week x 4 weeks, in clinical meeting, to ensure a thorough fall follow up assessment and neurological checks in place. Then 3 residents 3 x weekly x 8 weeks. DON/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 100% compliance achieved	

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	assessment of the resident's edema after 6/18/23. Interview with the Director of Nursing on 8/3/23 at 12:50 p.m., indicated she had no additional information to provide. The facility policy titled, "Fall Prevention and Management" was provided by the Administrator on 8/2/23 at 2:52 p.m. The policy indicated the Post Fall Assessment was to be completed and the Fall Follow Up was to be completed at least twice daily for 3 days unless the resident's condition was such that it should be continued longer. 2. The record for Resident K was reviewed on 8/2/23 at 3:20 p.m. Diagnoses included, but were not limited to, paraplegia, neuromuscular dysfunction of the bladder, depression, anxiety, anemia, and pain. The 7/17/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making. A Discharge Return Anticipated MDS assessment, dated 5/26/23, indicated the resident was sent to the hospital. There was no documentation in the nursing progress notes or an assessment of a change of condition or why the resident was discharged. There were also no vital signs checked that day. A Nurses' Note, dated 5/29/23 at 8:00 p.m., indicated the resident was readmitted from the hospital. Interview with the Director of Nursing on 8/3/23 at 12:50 p.m., indicated she had no additional			

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	information, however, she would expect nursing staff to document why the resident was being sent out to the hospital. This Federal tag relates to Complaints IN00413262 and IN00413351. 3.1-37(a)			
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 ensure daily wound assessments and treatments were completed as ordered and treatments were initiated in a timely manner for 2 of 3 residents reviewed for pressure ulcers. (Residents M and J) Findings include: 1. On 8/3/23 at 9:28 a.m., Resident M was observed in his room in bed. His feet were elevated on a pillow and bilateral heel boots were in use.	F 0686	1. Residents J and M were not harmed by the alleged deficient practice. Resident J no longer resides in the facility. Resident M was reviewed to ensure physician ordered treatment in place and daily wound assessments are in place and signed out as complete. 2. All residents with a Pressure Ulcer have the potential to be affected by same alleged deficient practice. All residents	08/18/2023

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	The record for Resident M was reviewed on 8/3/23 at 11:09 a.m. Diagnoses included, but were not limited to, stroke and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 7/20/23, indicated the resident was moderately impaired for daily decision making. The resident required extensive assistance with bed mobility and was totally dependent for transfers. He had three Stage 3 (full thickness tissue loss) pressure ulcers. The resident did not have a current care plan related to the pressure ulcers. A Physician's Order, dated 6/12/23, indicated the resident was to have a daily wound assessment completed for his left heel. Any abnormalities were to be documented in the progress notes. The June 2023 Medication Administration Record (MAR) indicated the daily wound assessment was not signed out as being completed on 6/12, 6/23, 6/24, 6/29, and 6/30/23. The July 2023 MAR indicated the daily wound assessment was not signed out as being completed on 7/2, 7/7, 7/11-7/14, 7/16, 7/17, and 7/26-7/28/23. A Physician's Order, dated 6/12/23, indicated the resident's left heel was to be cleansed with wound cleanser, apply medical grade honey with fiber (a debriding agent), and cover with bordered gauze daily and as needed (prn) every day shift. The June 2023 Treatment Administration Record (TAR) indicated the treatment was not signed out as being completed on 6/12, 6/23, 6/24, 6/29, and		with Pressure Ulcers have been audited to ensure that a physician ordered treatment is in place, treatment and daily wound assessment signed out as complete and observation completed to validate that all dressings are in place. Any areas of concern were immediately addressed with a physician ordered treatment, family notifications, pressure relief interventions and nutritional interventions. All audits completed by the DON/Designee by 8/18/23. 3. DON/Designee has educated all licensed nurses regarding wound care with the "Wound Care Overview" policy, with emphasis on "review and select the appropriate treatment for the identified skin impairment". All licensed nurses have been educated on Skin care and wound management, documentation standards, and wound monitoring. Emphasis and education regarding weekly skin assessment completion provided. 4. DON/ designee will review 5 residents with a wound to ensure a wound care treatment order is in place, and daily wound assessments and treatments are signed out and observation to validate dressing is in place 3 x wk x 12 wks. DON/Designee will report on audits monthly to the	

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	6/30/23. The July 2023 TAR indicated the treatment was not signed out as being completed on 7/2/23. A Physician's Order, dated 6/21/23, indicated the resident's left lateral plantar foot was to be cleansed with wound cleaner, apply Medihoney (a debriding agent), and cover with bordered gauze daily and prn. The June 2023 TAR indicated the treatment was not signed out as being completed on 6/23, 6/24, 6/29, and 6/30/23. The July 2023 TAR indicated the treatment was not signed out as being completed on 7/2, 7/6, 7/7, 7/9, 7/11-7/14, 7/16, 7/17, and 7/19/23. A Physician's Order, dated 7/5/23, indicated betadine (a topical antiseptic) was to be applied to the resident's left lateral plantar foot daily. The July 2023 TAR indicated the treatment was not signed out as being completed on 7/6, 7/7, and 7/9/23. A Physician's Order, dated 7/10/23, indicated the resident's left heel was to be cleansed with wound cleaner, apply medical grade honey, silver alginate (a wound dressing), and cover with a bordered foam dressing daily and prn. The July 2023 TAR indicated the treatment was not signed out as being completed on 7/11, 7/12, 7/13, 7/14, and 7/16/23. Interview with the Director of Nursing on 8/3/23 at 12:50 p.m., indicated the daily wound assessments should have been completed as ordered as well as		interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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the resident's treatments.
2. On 8/2/23 at 11:00 a.m., Resident J was observed laying flat in bed with heel boots to both of her feet and they were elevated on a pillow. At that time, the resident indicated she had a pressure sore on one of her heels.

The record for Resident J was reviewed on 8/2/23 at 2:20 p.m. Diagnoses included, but were not limited to, morbid obesity, depressive disorder, high blood pressure, angina, anemia, chronic kidney disease, and dementia without behaviors.

The Quarterly Minimum Data Set (MDS) assessment, dated 7/24/23, indicated the resident was moderately impaired for daily decision making and had 1 Stage 3 pressure ulcer (full thickness tissue loss) that was present upon admission.

A Care Plan, revised on 7/19/23, indicated the resident had a pressure ulcer to the right heel. The approaches were to administer treatments as ordered and evaluate the existing wound daily for changes.

Physician's Orders, dated 5/24/23, indicated Skin Prep Wipes (a skin barrier), were to be applied to the right heel every day shift for wound care. The order was discontinued on 6/12/23.

The Treatment Administration Record (TAR) for 6/2023, indicated the Skin Prep was signed out as being completed 6/1-6/11/23.

A Wound Nurse Practitioner (NP) Progress Note, dated 6/8/23, indicated it was the first evaluation of the right heel pressure ulcer. The wound was unstageable (full thickness tissue loss in which actual depth of the wound is completely obscured) and measured 2 centimeters (cm) by 2.1

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	cm with 100% of eschar (necrotic tissue). The treatment to be ordered was Betadine (a topical antiseptic) daily and leave open to air. Physician's Orders, dated 6/12/23 (4 days after the NP had ordered the new treatment), indicated Betadine to the right heel daily and leave open to air for wound healing. The order was discontinued on 6/14/23. The 6/2023 TAR indicated the treatment was signed out as being completed on 6/12 and 6/13/23. Physician's Orders, dated 6/14/23, indicated to cleanse the right heel with wound cleaner, apply medical grade honey (a debriding agent) and cover with a bordered gauze daily for wound healing. The TARs for 6/2023 and 7/2023 indicated the treatment for the medical honey was not signed out as being completed on 6/15, 7/11, 7/16, and 7/31/23. Physician's Orders, dated 5/23/23, indicated a daily wound assessment of the right heel was to be completed every shift. The TAR for 6/2023 and 7/2023 indicated the daily wound assessment for the right heel was not signed out as being completed at 5:00 a.m. on 6/1-6/6, 6/9, 6/12, 6/14-6/24, 6/26-6/28, 6/30, 7/1-7/5, 7/7-7/9, and 7/14-7/18/23. Interview with the Director of Nursing on 8/3/23 at 12:50 p.m., indicated she had no additional information. This Federal tag relates to Complaint IN00407169.			

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	3.1-40(a)(2)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 5 residents observed during medication pass. Two errors were observed during 29 opportunities for errors during medication administration. This resulted in a medication error rate of 6.89% (Residents N and P) Findings include: 1. On 8/3/23 at 9:44 a.m., RN 1 was observed preparing Resident N's medications. She dispensed one Extra Strength Tylenol 500 milligrams (mg), one Vitamin D3 25 micrograms (mcg)/1,000 units tablet, one Gabapentin (a medication used for nerve pain), and one Docusate Sodium 100 mg tablet. A total of 4 pills were observed in the medication cup. The record for Resident N was reviewed on 8/3/23 at 10:30 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, depressive disorder, and alcohol abuse. A Physician's Order, dated 4/5/23, indicated the resident was to receive a Cholecalciferol tablet 1,000 units, give 2 tablets by mouth daily for Vitamin D deficiency.	F 0759	1. Residents N and P were not harmed by the alleged deficient practice. The physician and responsible party were notified of the resident receiving one Vitamin D tablet in place of two tablets. The physician for resident P and the resident, as he is his own responsible party, were notified of the insulin administration outside of time frame parameters. Both were immediately assessed with no negative findings. 2. All residents receiving insulin injections and oral medications have the potential to be affected by same alleged deficient practice. All residents receiving oral medications have been audited to ensure they are receiving the physician ordered dose. All residents receiving insulin injections have been audited to ensure insulin administration within the established time frame, per facility policy. These audits wer complete by the DON/Designee by 8/18/23. Any discrepancies in dose or deviation from time frame were	08/18/2023

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	Interview with the Director of Nursing on 8/3/23 at 3:00 p.m., indicated the resident should have received the correct dose of Vitamin D3. 2. On 8/3/23 at 10:06 a.m., RN 1 was preparing Resident P's insulin injection. The resident was to receive 10 units of Aspart insulin for a blood sugar of 264. The RN entered the resident's room and the insulin was administered at 10:10 a.m. The record for Resident P was reviewed on 8/3/23 at 11:05 a.m. Diagnoses included, but were not limited to, respiratory failure and type 2 diabetes mellitus. A Physician's Order, dated 5/25/23, indicated the resident was to receive Insulin Aspart subcutaneously, inject per sliding scale four times a day with meals and at bedtime. Inject as per sliding scale: if 150 - 200 = 5 units; 201 - 250 = 7 units; 251 - 300 = 10 units; 301 - 350 = 15 units; 351 - 400 = 20 units Call the Physician if the blood sugar was less than 60 or greater than 400. The scheduled administration time was at 8:00 a.m. Interview with the Director of Nursing on 8/3/23 at 3:00 p.m., indicated the resident should have received his insulin in a more timely manner. This Federal tag relates to Complaint IN00413483. 3.1-48(c)(1)		immediately corrected, physician and family notifications complete. 3. DON/Designee has educated all licensed nurses and QMA's on the Medication Administration policy and the Missed Medication/Medication Error policy. 4. DON/Designee will observe the administration of oral medications and insulin injections for 5 residents wkly x 8 weeks. DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only			

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	08/03/2023

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	when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.			
	Based on record review and interview, the facility failed to ensure specimens for laboratory testing were collected as ordered by the Physician and abnormal results were reported to the Physician in a timely manner for 1 of 3 residents reviewed for laboratory testing. (Resident E) Finding includes: The closed record for Resident E was reviewed on 8/1/23 at 2:00 p.m. Diagnoses included, but were not limited to, wedge compression fracture, paraplegia, uropathy, depressive disorders, urine retention, schizophrenia, history of falling, and anemia. The Annual Minimal Data Set (MDS) assessment, dated 6/15/23, indicated the resident was moderately impaired for decision making. The resident was an extensive assist with 1 person physical assist for bed mobility and toilet use. She needed supervision for transfers and was independent for locomotion off the unit. A Nurses' Note, dated 6/16/23 at 12:44 p.m., indicated the resident's POA (Power of Attorney) phoned in with medical concerns regarding the resident's condition. The Physician was notified and new orders were received for labs of a CBC	F 0773	1. Resident E was not harmed by the alleged deficient practice. The resident no longer resides at the facility. 2. All residents receiving laboratory testing have the potential to be affected by the alleged deficient practice. All residents that have received a lab draw in the last 14 days have been audited to ensure completion of the test as ordered and timely notification to the physician/NP of any abnormal results. Any findings were immediately corrected, physician and responsible party notifications completed. Audit completed by the DON/Designee by 8/18/23. 3. DON/designee have educated all licensed nursing staff regarding the Physician Order policy with an emphasis on following physician orders. DON/Designee have educated all licensed nurses on the Laboratory	08/18/2023

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	(Complete Blood Count) and a BMP (Basic Metabolic Panel) to be drawn on 6/19/23. The Physician also ordered x-rays of the lower back and bilateral knees. The medication of Lasix (a diuretic) 20 milligrams (mg) daily related to bilateral lower extremity swelling was also ordered. A Physician's Order, dated 6/16/23, indicated the resident was to have a CBC and CMP (Complete Metabolic Panel). The labs were reported to the facility on 6/19/23 at 3:24 p.m. Abnormal lab findings were as follows: WBC (White Blood Cells) 11.96 a high value (4.5-11.0 normal) Glucose 40 a low value (70-110 normal) BUN (Blood Urea Nitrogen) 38 a high value (7-28 normal) Calcium 6.9 a low value (8.7-10.5 normal) Albumin 1.6 a low value (3.2-4.9 normal) A hand written note on the bottom of the lab page indicated, "6/20/23 Dr. paged awaiting call back." Another hand written note indicated, "6/21/23 1:19 p.m., Called MD-went to vm [voicemail]-mailbox is full." The last hand written note indicated, "6/21/23 at 1:46 p.m., MD notified, new orders received." On the very bottom of the lab page a hand written order indicated, "UA and check glucose times 2 days." Nurses' Notes, dated 6/20/23 at 9:18 p.m., indicated the Medical Doctor was called and a message was left to call the facility back regarding the resident's lab results. There was no return answer at that time.		and Radiological Services and Results Reporting, with an emphasis on timely reporting of results. 4. DON/Designee will audit 5 residents ordered to receive laboratory testing wkly x 8 weeks to ensure completion of the laboratory test as ordered and timely reporting to the physician/NP. The DON will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	Nurses' Notes, dated 6/21/23 at 1:51 p.m., indicated the Medical Doctor was notified of the lab results from 6/19/23. New orders were received to collect a urine sample for a urinalysis with a culture. The resident was encouraged to consume fluids. There was no documentation of a Physician's Order for the glucose check. A blood glucose of 49 was documented on 6/23/23 at 7:51 a.m. There were no other documented glucose levels in the resident's clinical record. Interview with the Director of Nursing on 8/3/23 at 12:50 p.m., indicated she had no additional information to provide. This Federal tag relates to Complaint IN00413262. 3.1-49(f)(1) 3.1-49(f)(2)			