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	01/12/2024

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00417995, IN00418377, IN00420481, IN00421650, IN00423615, IN00425401, and IN00425825. Complaint IN00417995 - Federal/state deficiencies related to the allegations are cited at F921. Complaint IN00418377 - No deficiencies related to the allegations are cited. Complaint IN00420481 - Federal/state deficiencies related to the allegations are cited at F690. Complaint IN00421650 - No deficiencies related to the allegations are cited. Complaint IN00423615 - Federal/state deficiencies related to the allegations are cited at F921. Complaint IN00425401 - No deficiencies related to the allegations are cited. Complaint IN00425825 - No deficiencies related to the allegations are cited. Survey dates: January 8, 9, 10, 11, and 12, 2024 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Census Bed Type: SNF/NF: 112 Total: 112	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 cordially requests paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason Eastlund	Executive Director	02/06/2024

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.

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	01/12/2024

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
	Census Payor Type: Medicare: 9 Medicaid: 76 Other: 27 Total: 112 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/22/24.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 3 of 4 residents reviewed for self-administration of medication. (Residents 43, 52, and 15) Findings include: 1. During random observations on 1/8/24 at 10:30 a.m., and 2:10 p.m., Resident 43 was observed in bed. At those times, there was a tube of Bacitracin ointment on the over bed table. The record for Resident 43 was reviewed on 1/10/24 at 10:25 a.m. Diagnoses included, but were not limited to, bipolar disorder, atrial fibrillation, anxiety, major depressive disorder, dementia, and schizophrenia. The 12/30/23 Annual Minimum Data Set (MDS) assessment indicated the resident was moderately	F 0554	1 Residents 43, 52 and 15 were not harmed by the alleged deficient practice. Residents 43, 52 and 15 were assessed by licensed nurses and were not noted with any adverse effects related to the alleged deficient practice. Resident 52 had a medication self-administration observation completed and is deemed safe to self-administer medications. Residents 43 and 15 had medications removed from the bedside. 2 All residents who take medications have the potential to be affected by the same alleged deficient practice. All residents' rooms have been observed to ensure that there are not any medications at the bedside.	02/03/2024

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	01/12/2024

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
	impaired for decision making. There was no Care Plan for the resident to self-administer her own medications. There was no Physician's Order for the Bacitracin ointment or for the resident to self-administer her own medications. There was no self-administer of medications assessment completed. During an Interview on 1/11/24 at 2:15 p.m., the Director of Nursing indicated residents were not to self-administer their own medications without an order or an assessment. 2. During random observations on 1/8/24 at 10:43 a.m., 2:54 p.m., on 1/9/24 at 11:12 a.m., and 2:08 p.m., and on 1/10/24 at 9:23 a.m., Resident 52 was observed in bed. At those times, there were 2 bottles of Bismuth tablets and 1 tube of bio freeze in a container on his over bed table. The record for Resident 52 was reviewed on 1/10/24 at 12:00 p.m. Diagnoses included, but were not limited to, morbid obesity, high blood pressure, bipolar disorder, recurrent depressive disorders, schizophrenia, neuropathy, low back pain, anxiety disorder, and chronic pain. The Quarterly Minimum Data Set (MDS) assessment, dated 11/28/23, indicated the resident was cognitively intact. There was no Care Plan for the resident to self-administer his own medications. There were no Physician's Orders for the Bismuth tablets and the bio freeze or for the resident to self-administer his own medications. There was no self-administer of medications assessment completed. During an interview on 1/11/24 at 2:15 p.m., the		3 DON/Designee has educated licensed nurses and department heads on bedside medication policy and procedures. 4 DON/designee will conduct audits 3X per week for 12 weeks with a focus on observing for unsupervised medications at the bedside. 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 95% compliance achieved.	

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	01/12/2024

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
	Director of Nursing indicated residents were not to self-administer their own medications without an order or an assessment.3. On 1/8/24 at 2:14 p.m.,Resident 15 was observed in her room . On the over bed table, there was a bottle of fish oil capsules. On 1/9/24 at 2:17 p.m. and on 1/10/24 at 10:18 a.m., the bottle of fish oil capsules remained on the over bed table in her room. The record was reviewed for Resident 15 on 1/10/24 at 2:31 p.m. Diagnoses included, but were not limited to, anemia (low iron), hypertension (high blood pressure), diabetes , depression, and pressure ulcer. The 12/11/23 Annual Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making. There was no Care Plan to self-administer her medications. There was no self-administer of medications assessment completed for the resident. There was no Physician's Order for the fish oil capsules. During an interview on 1/10/23 at 2:22 p.m., the Director of Nursing (DON) indicated residents should not have any medications at the bedside, and she would follow up immediately. 3.1-11(a)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes.			

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	01/12/2024

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
	(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15)			

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	01/12/2024

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
	Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to ensure the resident's Responsible Party was notified of a change in condition for 1 of 1 residents reviewed for notification of change. (Resident 63) Finding includes: The record for Resident 63 was reviewed on 1/10/24 at 3:30 p.m. Diagnoses included, but were not limited to, stroke, COPD, high blood pressure, kidney failure, and muscle weakness. The 10/8/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact, had no behaviors, and received oxygen. The resident had no oral problems and received 51% or more of his nutrition through a peg tube (a tube inserted directly into the stomach for nutrition). A Nurses' Note, dated 12/19/23 at 7:45 a.m., indicated the resident's peg tube was dislodged and was infusing in the resident's bed. At that time, a foley catheter was placed in the insertion site. There was clumpy enteral feeding running out of the tubing. The cap was placed on the tubing and the NP and Unit Manager were made aware. A Nurses' Note, dated 12/19/23 at 8:05 a.m.,	F 0580	**F 580** **Notify of Changes** 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.** 1 Resident 63 was not harmed by the alleged deficient practice. Family was notified of the previous change of condition. 2 All residents, who have a change of condition, have the potential to be affected by same alleged deficient practice. All residents with a G-tube had their chart audited to ensure that any changes of condition related to their G-tube has had family notifications.	02/03/2024

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	01/12/2024

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
	indicated the resident's peg tube was dislodged and was replaced with a foley catheter tubing. The Physician was aware, however, there was no documentation the resident's Responsible Party was notified. Nurses' Notes, dated 12/19/23 at 10:30 a.m., indicated the NP (Nurse Practitioner) ordered a stat X-ray of the abdomen. The X-ray was taken on 12/20/23 at 12:55 a.m. Nurses' Notes, dated 12/20/23 at 1:49 p.m., indicated a new order for the resident to receive a Fleets enema was obtained. There was no documentation the resident's Responsible Party was made aware of the X-ray results or the new order for the Fleets enema. Nurses' Notes, dated 12/31/23 at 2:03 p.m., indicated the resident was observed with dried drainage around his right eye. The information was passed on to the p.m. nurse. There was no documentation the resident's Responsible Party was made aware of the drainage. Nurses' Notes, dated 1/6/24 at 6:13 a.m., indicated the resident's peg tube was clogged and not functioning. The Physician was notified and new orders were obtained to send the resident out to the hospital. The resident's Responsible Party was called but did not answer, so a voice message was left for her to call the facility. . A Nurses' Note, dated 1/6/24 at 4:46 p.m., indicated the resident returned back to the facility with a new peg tube. There was no documentation the resident's Responsible Party was notified. During an interview on 1/11/24 at 2:15 p.m., the		3 DON/Designee has educated licensed nurses on the notification policy for change in condition. 4 DON/Designee will audit all residents with a change of condition, related to their G-tube, and ensure that notifications, responsible party, has been completed 3x per week x 12 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 95% compliance achieved.	

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	01/12/2024

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
	Director of Nursing (DON) indicated there was no documentation the resident's family was notified of the changes in condition as described above. 3.1-5(a)(2)			
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of			

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	01/12/2024

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
	the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, record review, and interview, the facility failed to ensure a resident had privacy during a physical exam by the Nurse Practitioner (NP) for 1 of 1 residents reviewed for privacy. (Resident 63) Finding includes: During a random observation on 1/10/24 at 9:50 a.m., the NP was observed performing an assessment on Resident 63 in the lounge area on the West Unit. At that time, there were 2 other residents sitting in their wheelchairs in the room. The NP proceeded to assess the resident as he lifted up the resident's shirt and pressed on his abdomen with his bare hands. He then lifted up his pant leg and felt his calves with his bare hands. He took his stethoscope and placed it on the resident's bare abdomen and listened and then listened to his heart. The resident was observed with a peg tube (a tube inserted directly into the stomach for nutrition). He documented his findings on an IPad and then stood up and left the lounge area. The record for Resident 63 was reviewed on 1/10/24 at 3:30 p.m. Diagnoses included, but were not limited to, stroke, dysphagia, high blood pressure, kidney failure, and muscle weakness. The 10/8/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact, received a mechanically altered diet and had feeding tube in which he received 51% or more of his nutrition.	F 0583	**F 583** **Personal Privacy/Confidentiality of Records** 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.** 1 Resident 63 was not harmed by the alleged deficient practice. Resident 63 had a psychosocial assessment completed to ensure no adverse effects were noted related to the alleged deficient practice. 2 All residents', who require an assessment, have the potential to be affected by the same deficient practice. ED completed a random audit of all units to identify any privacy issues. 3 DON/Designee provided education to the Nurse	02/03/2024

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	01/12/2024

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
	The State Optional MDS assessment, dated 10/8/23, indicated the resident needed extensive assist for activities of daily living. During an interview on 1/11/24 at 9:45 a.m., the Director of Nursing indicated the NP should have provided privacy while completing the assessment for the resident by removing him from the lounge and taking him back to his room. 3.1-3(p)(4)		Practitioner and the Staff Licensed Nurses related to the resident rights to privacy. 4 ED/Designee will interview 5 residents weekly to ensure that their privacy is being maintained during physical assessments. Interviews will be conducted for 12 weeks. ED/designee will report all negative findings to monthly QAPI meeting for a period of 6 months.	
F 0623 SS=A Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.			

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	01/12/2024

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
	(ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency			

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	01/12/2024

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
	responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on record review and interview, the facility failed to ensure the resident's Responsible Party was notified in writing related to a transfer to the hospital for 3 of 3 residents reviewed for hospitalization. (Residents 60, 12, and 63)	F 0623	No POC required	02/03/2024

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	01/12/2024

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
	Findings include: 1. The record for Resident 60 was reviewed on 1/9/24 at 2:32 p.m. Diagnoses included, but were not limited to, hemiplegia (muscle weakness) following a stroke, type 2 diabetes, chronic obstructive pulmonary disease (COPD), and dementia with behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 12/5/23, indicated the resident was cognitively impaired for daily decision making. Nurses' Notes, dated 12/11/23 at 8:20 a.m., indicated the resident was unresponsive to verbal commands and stimuli. His blood pressure was 84/52 and his oxygen saturation was 92%. The resident was assessed by the Nurse Practitioner and orders were received to send the resident to the emergency room for evaluation. 911 was called and his daughter was made aware. The resident was admitted to the hospital with altered mental status and returned to the facility on 12/15/23. There was no indication the State transfer form was mailed to the resident's responsible party. During an interview on 1/11/24 at 3:00 p.m., the Director of Nursing indicated a copy of the State transfer form should have been mailed to the resident's family. 2. The record for Resident 12 was reviewed on 1/10/24 at 9:45 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes, high blood pressure, adult failure to thrive, osteoarthritis, sleep apnea, COPD and coronary graft.			

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	01/12/2024

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
	The 10/15/23 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact. A Nurses' Note, dated 10/2/23 at 7:30 p.m., indicated the resident was observed with course and crackled lung sounds. His vital signs were abnormal, the Physician was called and orders to send the resident to the hospital were obtained. The son was unreachable at that time. The resident was admitted to the hospital and returned on 10/4/23. There was no documentation the State transfer form including the bed hold policy was mailed to the resident's Responsible Party. During an interview on 1/10/24 at 10:13 a.m., LPN 6 indicated at the time of discharge they send the State transfer form with the resident and a copy was made and given to medical records. During an interview on 1/10/24 at 10:22 a.m., the Medical Records Supervisor indicated she either scanned the form into the chart or placed a copy in the hard chart. She was unaware who was in charge of mailing the form to the family. During an interview on 1/10/24 at 11:30 a.m., the Administrator indicated nursing staff called the residents' families and gave them verbal notification at the time of discharge. If the resident was alert and oriented they gave the form to the resident at the time of discharge. He indicated the Business Office Manager would mail them to the family, however, there was no documentation the form had been mailed after he was sent to the hospital on 10/2/23.			

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	01/12/2024

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
	During an interview on 1/10/24 at 11:45 a.m., the resident's son indicated he did not receive any type of bed hold policy or State transfer form in the mail when his dad was admitted to the hospital. 3. The record for Resident 63 was reviewed on 1/10/24 at 3:30 p.m. Diagnoses included, but were not limited to, stroke, COPD, high blood pressure, kidney failure, and muscle weakness. The 10/8/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact, had no behaviors, and received oxygen. The resident had no oral problems and received 51% or more of his nutrition through a peg tube (a tube inserted directly into the stomach for nutrition). Nurses' Notes, dated 1/6/24 at 6:13 a.m., indicated the resident's peg tube was clogged and not functioning. The Physician was notified and new orders were obtained to send the resident out to the hospital. The resident's Responsible Party was called but did not answer, so a voice message was left for her to call the facility. . There was no documentation the State transfer form was mailed to the resident's Responsible Party. During an interview on 1/10/24 at 11:30 a.m., the Administrator indicated nursing staff called the residents' families and gave them verbal notification at the time of discharge. If the resident was alert and oriented they gave the form to the resident at the time of discharge. He indicated the Business Office Manager would mail them to the family, however, there was no documentation the form had been mailed after he was sent to the			

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	01/12/2024

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
	hospital on 1/6/24. 3.1-12(a)(6)(A)(ii)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to antiplatelet medication use for 1 of 26 MDS assessments reviewed. (Resident 96) Finding includes: The record for Resident 96 was reviewed on 1/11/24 at 9:39 a.m. Diagnoses included, but were not limited to, fracture of the lower end of the left and right femurs, diabetes mellitus, and acute embolism and thrombosis. The Admission Minimum Data Set (MDS) assessment, dated 10/16/23, indicated the resident was cognitively intact and she was receiving an anticoagulant (blood thinner) medication. Antiplatelet medication was not coded. A Physician's Order, dated 10/11/23, indicated the resident was to receive Brilinta (an antiplatelet medication) 90 milligrams (mg) twice a day for the prevention of a blood clot. During an interview on 1/11/24 at 3:00 p.m., the Director of Nursing indicated the MDS was coded inaccurately. During an interview on 1/12/24 at 11:00 a.m., the	F 0641	No POC required.	02/03/2024

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	01/12/2024

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
	MDS Coordinator indicated the resident was receiving Lovenox (an anticoagulant) and Brilinta during the assessment reference period. She indicated the Brilinta should have been coded as an antiplatelet. 3.1-31(i)			
F 0657 SS=A Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility	F 0657	No POC required.	02/03/2024

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	01/12/2024

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
	failed to ensure the comprehensive care plan was revised after medications were discontinued for 3 of 26 care plans reviewed. (Residents 42, 73, and 96) Findings include: 1. The record for Resident 42 was reviewed on 1/11/24 at 2:03 p.m. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, stroke, recurrent depressive disorder, and dementia with behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 12/10/23, indicated the resident was cognitively impaired for daily decision making and he was not receiving an antidepressant medication. A Care Plan, revised on 12/9/23, indicated the resident used an antidepressant medication (Sertraline) related to depression. The resident's Sertraline had been discontinued on 2/24/23. During an interview on 1/12/24 at 11:00 a.m., the MDS Coordinator indicated the resident's care plan would be updated. 2. The record for Resident 73 was reviewed on 1/11/24 at 12:06 p.m. Diagnoses included, but were not limited to, psychotic disorder with delusions and schizoaffective disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 12/31/23, indicated the resident was moderately impaired for daily decision making. He had not received an antipsychotic medication during the assessment reference			

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	01/12/2024

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
	period. A Care Plan, dated 12/31/23, indicated the resident received an antipsychotic medication Quetiapine related to psychosis and sleeplessness. The resident's Quetiapine was discontinued on 10/25/22. During an interview on 1/11/24 at 3:00 p.m., the Director of Nursing indicated the resident's care plan would be updated. 3. The record for Resident 96 was reviewed on 1/11/24 at 9:39 a.m. Diagnoses included, but were not limited to, fracture of the lower end of the left and right femurs, diabetes mellitus, and acute embolism and thrombosis. The Admission Minimum Data Set (MDS) assessment, dated 10/16/23, indicated the resident was cognitively intact and she was receiving an anticoagulant (blood thinner) medication. A Care Plan, reviewed and revised on 1/14/24, indicated the resident was at risk for abnormal bleeding or hemorrhage due to anticoagulant (blood thinner) use. The resident's Lovenox (an anticoagulant) was discontinued on 11/10/23. During an interview on 1/11/24 at 3:18 p.m., the Director of Nursing indicated the care plan would be updated. 3.1-35(d)(2)(B)			
F 0677 SS=D	483.24(a)(2) ADL Care Provided for Dependent Residents			

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	01/12/2024

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
Bldg. 00	§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure dependent residents received assistance with activities of daily living (ADL's) related to nail care and the removal of facial hair for 3 of 8 residents reviewed for ADL's. (Residents 12, 47, and 63) Findings include: 1. On 1/8/24 at 1:52 p.m., on 1/9/24 at 11:00 a.m. and 2:05 p.m., and on 1/10/24 at 9:36 a.m., Resident 12 was observed with long and dirty fingernails as well as a full beard. The record for Resident 12 was reviewed on 1/10/24 at 9:45 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes, high blood pressure, adult failure to thrive, osteoarthritis, sleep apnea, COPD and coronary graft. The 10/15/23 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact. The 10/15/23 State Optional MDS assessment, indicated the resident was an extensive assist with ADL's. There was a current Care Plan indicating the resident needed assistance with personal hygiene. There was no Care Plan indicating the resident refused care or that he liked having long fingernails or a full beard.	F 0677	**F677** **ADL Care for Dependent Residents** 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.** 1 Residents 12, 47 and 63 were not harmed by the alleged deficient practice. Residents 12 and 63 had already had their nail cleaned and trimmed prior to survey exit. Resident 47 had her facial hair removed prior to survey exit. 2 DNS/Designee completed a whole house audit of resident nails and facial hair, prior to date of compliance. Any negative findings were immediately addressed. 3 DON/Designee has educated the Nursing Staff	02/03/2024

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	01/12/2024

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
	The resident had a shower on 1/6/24 and there was no documentation his nails were trimmed or cleaned or he was shaved. During an interview on 1/10/24 at 11:45 a.m., the resident's son indicated his dad does not like having a beard and preferred to be clean shaven. During an interview on 1/11/24 at 11:10 a.m., the Director of Nursing indicated the resident's nails should have been cleaned and clipped and he should have been shaved. 2. On 1/8/24 at 9:55 a.m., Resident 47 was observed with a large amount of facial hair on her chin. The facial hair remained on her chin on 1/8/24 at 1:52 p.m., on 1/9/24 at 11:00 a.m., and on 1/10/24 at 9:45 a.m. The record for Resident 47 was reviewed on 1/10/24 at 3:00 p.m. Diagnoses included, but were not limited to dementia, high blood pressure, syncope, delirium, pain, and acute kidney failure. The 12/22/23 Annual Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact. The 12/22/23 State Optional MDS assessment, indicated the resident required assistance with ADL's. There was a current Care Plan indicating the resident needed assistance with personal hygiene. There was no Care Plan the resident refused care. The resident received a shower on 1/4 and 1/8/24 and there was no documentation her facial hair		regarding on policy of routine ADL assistance, with an emphasis on facial grooming and nail care. 4 DON/Designee will perform random observations on 5 residents 3X per week X 12 weeks, to ensure nails are clean and trimmed and that females, who do not want hair on their face, have the hair removed in a timely manner. 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 95% compliance achieved.	

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	01/12/2024

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
	was removed. During an interview on 1/11/24 at 11:10 a.m., the Director of Nursing indicated the resident's facial hair should have been removed. 3. On 1/8/24 at 11:25 a.m., and 3:03 p.m., on 1/9/24 at 10:54 a.m., and 2:04 p.m., and on 1/10/24 at 9:20 a.m., Resident 63 was observed with long and dirty fingernails as well as a large amount of facial hair. The record for Resident 63 was reviewed on 1/10/24 at 3:30 p.m. Diagnoses included, but were not limited to, stroke, dysphagia, high blood pressure, kidney failure, and muscle weakness. The 10/8/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact and had no behaviors of refusing care. The State Optional MDS assessment, dated 10/8/23, indicated the resident needed extensive assist for ADL's. There was a current Care Plan indicating the resident needed assistance with personal hygiene. There was no Care Plan the resident refused ADL care. The resident had a shower on 1/5/24 and there was no documentation he received nail care or a shave. A Nurses' Note, dated 1/10/24 at 7:43 a.m., indicated the resident refused nail care and a shave today.			

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	01/12/2024

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
	There was no other documentation in Nurses' Notes regarding refusal of care. During an interview on 1/11/24 at 9:45 a.m., the Director of Nursing indicated the resident should have been shaved and his nails trimmed and cleaned as needed. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			
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 observation, record review, and interview, the facility failed to ensure areas of bruising were assessed and monitored for 1 of 4 residents reviewed for skin conditions non-pressure related. (Resident 96) Finding includes: On 1/8/24 at 11:15 a.m., Resident 96 was observed with two fading bruises to her left upper arm. During an interview with the resident at that time, she indicated she was not sure how she got the bruises and "maybe they were from my insulin shots." The record for Resident 96 was reviewed on 1/11/24 at 9:39 a.m. Diagnoses included, but were	F 0684	**F684** **Quality of Care** 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.**	02/03/2024

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	01/12/2024

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
	not limited to, fracture of the lower end of the left and right femurs, diabetes mellitus, and acute embolism and thrombosis. The Admission Minimum Data Set (MDS) assessment, dated 10/16/23, indicated the resident was cognitively intact and she was receiving an anticoagulant (blood thinner) medication. The resident had no order to monitor the bruising to the left upper arm. A Physician's Order, dated 10/11/23, indicated the resident was to receive Brilinta (an antiplatelet medication) 90 milligrams (mg) twice a day for prevention of a blood clot. A Physician's Order, dated 11/11/23, indicated the resident was to receive Aspirin 325 mg daily for a blood thinner. The Weekly Skin assessment, dated 1/6/24, indicated the resident had no skin areas. During an interview with the Director of Nursing on 1/11/24 at 3:18 p.m., indicated the areas of bruising should have been monitored. 3.1-37(a)		1 Residents 96 was not affected by the alleged deficient practice. Resident 96 had a complete skin assessment completed with no additional skin abnormalities noted. NP made aware of bruising. 2 All residents, who have bruises, have the potential to be affected by the alleged deficient practice. Full house observation completed on all in-house residents to ensure that all bruising is being monitored. 3 DON/Designee will educate Nursing staff on the non-pressure skin policy with an emphasis on bruising and ensuring that all resident bruising is identified and daily monitoring of the bruising is being completed. 4 DON/Designee will perform random observations of 5 residents' skin 3 X per week X 12 weeks to ensure that any skin alteration is being monitored according to facility protocol. DON/Designee will report on observations monthly to the interdisciplinary team for 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6	

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	01/12/2024

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
			months with 95% compliance achieved.	
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 residents with pressure ulcers received the necessary treatment and services to promote healing, related to treatments not completed as ordered for 1 of 4 residents reviewed for pressure ulcers. (Resident 213) Finding includes: During a pressure ulcer treatment on 1/10/24 at 8:10 a.m., Resident 213 was observed with 6 pressure ulcers. The right inner knee, left inner knee, right hip, and right shoulder were noted with black eschar (necrotic tissue) and had pink tissue on the surrounding skin. The right cheek was pink in color with yellow slough (necrotic tissue) noted and the right ear had hard black necrotic tissue.	F 0686	**F686** 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.** 1 Resident 213 was not affected by the alleged deficient practice. Resident had wound assessed and no adverse effects	02/03/2024

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	01/12/2024

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
	The record for Resident 213 was reviewed on 1/9/24 at 2:20 p.m. The resident was admitted to the facility on 12/30/23. Diagnoses included, but were not limited to, fall, intellectual disabilities, high blood pressure, and reduced mobility. The Admission Minimum Data Set (MDS) assessment was in progress and not completed. The Care Plan, dated 12/30/23, indicated the resident had impaired skin integrity and was at risk for altered skin integrity. Physician's Orders, dated 1/3/24, indicated to apply betadine to the right upper cheek three times a day and leave open to air. Cleanse the right lateral knee and right hip with wound cleanser, apply medical grade honey, and cover with a bordered gauze every day shift. The 1/2024 Treatment Administration Record (TAR) indicated the right upper cheek was not signed out as being completed on 1/6 and 1/7 for the day shift and on 1/7 for the night shift. The right lateral knee and right hip was not signed out as being completed on 1/6 and 1/7/24. During an interview on 1/11/24 at 8:45 a.m., the Wound Nurse indicated the bandages were to be changed daily as ordered by the Physician. During an interview on 1/11/24 at 11:10 a.m., the Director of Nursing indicated treatments were to be signed out after they were completed. 3.1-40(a)(2)		were noted related to wound treatment not being documented on the Treatment Administration Record. 2 All residents, who require wound treatments that must be signed out on the treatment administration record, have the potential to be affected by the same deficient practice. DNS/designee conducted a review of all resident with pressure ulcers to ensure orders, care plans and TARs were marked out appropriately. 3 DON/Designee provided education to all Licensed Nurses regarding ensuring that all wound treatments are completed and documented on the Treatment Administration Record as ordered. 4 DON/Designee will perform 5 random TAR observations 3 x per week x 12 weeks to ensure that Licensed Nurses are completing and signing out their wound treatments on the Treatment Administration Record daily. DON/designee will report all negative findings to monthly QAPI meeting for a period of 6 months.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence.			

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	01/12/2024

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
	§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, record review, and interview, the facility failed to ensure a resident's urostomy was documented and monitored for 1 of 2 residents reviewed for catheters. (Resident D) Finding includes:	F 0690	**F690** Preparation and execution of this plan of correction does not constitute admission or agreement	02/03/2024

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	01/12/2024

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
	On 1/8/24 at 10:49 a.m., Resident D was observed in his room in bed. The resident indicated he had an urostomy bag. The resident's daughter indicated the resident continued to get urinary tract infections because the staff only changed the urostomy bag every month. The record for Resident D was reviewed on 1/10/24 at 10:55 a.m. Diagnoses included, but were not limited to, end stage renal disease, malignant neoplasm of the bladder, acquired absence of the kidney and an urostomy to the left lower quadrant. The Quarterly Minimum Data Set (MDS) assessment, dated 11/16/23, indicated the resident was moderately impaired for daily decision making, required substantial assistance with toileting, and had an urostomy. A Care Plan, updated on 11/16/23, indicated the resident had an urostomy related to bladder cancer and a history of urinary tract infections. Interventions included, but were not limited to, report and observe for blood tinged urine, consistency, eating patterns, changes in mental status, changes in amount of urine produced, fever and increased vitals. There were no Physician's Orders for the care, changing the bag/wafer, or monitoring the urostomy. During an interview on 1/10/24 at 9:15 a.m., RN 4 indicated there was no documentation the resident had an urostomy. During an interview on 1/10/24 at 10:49 a.m., the Director of Nursing indicated the resident went to		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.** 1 Resident D was not affected by the alleged deficient practice. Resident had urostomy assessed and no adverse effects were noted related to not having orders to monitor the urostomy. Orders were placed to monitor the urostomy every shift and monitor the output. . 1 All residents, who have a urostomy, have the potential to be affected by the same deficient practice. Full house audit completed on all residents who have a urostomy to ensure that they are all being monitored as ordered. 2 DON/Designee provided education to Licensed Nurses regarding ensuring that all residents who have a urostomy have orders to monitor the urostomy and monitor the output as ordered. 3 DON/Designee will audit all	

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	01/12/2024

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
	the hospital and when he returned, the orders were not reactivated. The current, "Stable Suprapubic Catheter Routine Care" policy, provided by Director of Nursing on 1/10/24 at 2:07 p.m., indicated routine daily catheter care may be a delegated task for long term and well healed long term suprapubic catheters as evaluated by a nurse. New or unstable suprapubic catheter care will be performed by a licensed nurse. This citation relates to Complaint IN00420481. 3.1-41(a)(1)		residents who have urostomy weekly x 12 weeks to ensure that they have orders to monitor the urostomy every shift and to monitor the output every shift. DON/designee will report all negative findings to monthly QAPI meeting for a period of 6 months.	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and			

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	01/12/2024

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
	nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure enteral tube feeding was infusing at the correct flow rate through a peg tube (a tube inserted directly into the stomach for nutrition) for 1 of 2 residents reviewed for tube feeding. (Resident 63) Finding includes: On 1/8/24 at 11:25 a.m., and 3:03 p.m., on 1/9/24 at 10:54 a.m., and 2:04 p.m., and on 1/10/24 at 9:20 a.m., 9:34 a.m.,and 9:50 a.m., Resident 63 was observed with an enteral tube feeding infusing at 65 cubic centimeters (cc) per hour into his peg tube. On 1/10/24 at 2:30 p.m., the resident was observed in bed and the tube feed was off and not infusing. The record for Resident 63 was reviewed on 1/10/24 at 3:30 p.m. Diagnoses included, but were not limited to, stroke, dysphagia, high blood pressure, kidney failure, and muscle weakness. The 10/8/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact, received a mechanically altered diet and had feeding tube in which he received 51% or more of his nutrition. A Care Plan, revised on 12/18/23, indicated the resident was at nutritional risk related to a history of weight loss. The approaches were to provide the diet as ordered and to provide the enteral feeding as ordered by the Physician. Physician's Orders, dated 11/16/23, indicated enteral tube feeding of Glucerna 1.5 continuously via the peg tube at 50 cc per hour.	F 0693	**F693** **Tube Feeding Management/Restore Eating Skills** 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.** 1 Resident 63 was not affected by the alleged deficient practice. Resident was assessed and no adverse effects were noted related to tube feeding not being administered at the correct rate. Rate was adjusted to correct infusion. 2 All residents, who receive enteral feedings, have the potential to be affected by the same deficient practice. All residents that receive enteral feedings were observed to ensure that all residents were receiving enteral feeding according to the physician ordered rate.	02/03/2024

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	01/12/2024

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
	During an interview on 1/11/24 at 8:50 a.m., LPN 2 indicated she noticed the tube feeding was infusing at the wrong rate yesterday during the late morning, so she changed it back to 50 cc per hour. The resident was being put back to bed right before she left yesterday around 2:00 p.m., so maybe the nurse had not turned the tube feeding back on after he was in bed. During an interview on 1/11/24 at 11:10 a.m., the Director of Nursing indicated the rate of the enteral feeding should have been infusing as ordered by the Physician. 3.1-44(a)(2)		3 DON/Designee provided education to all Licensed Nurses regarding ensuring that all residents, who are receiving enteral feedings, have the tube feeding pumped checked every shift to ensure the feeding is being administered at the proper rate. 4 RD/Designee will perform observations 3 x per week x 12 weeks on all residents who are receiving enteral feedings to ensure that the feeding is being administered at the correct rate. RD/designee will report all negative findings to monthly QAPI meeting for a period of 6 months.	
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 oxygen was on and set at the correct flow rate, and nebulizer treatments were completed in a timely manner for 2 of 3 residents reviewed for respiratory care and 1 of 1 nebulizer treatments observed. (Residents 63	F 0695	**F695 Respiratory/Tracheostomy Care and Suctioning** Preparation and execution of this plan of correction does not	02/03/2024

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	01/12/2024

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
	and 312) Findings include: 1. On 1/8/24 at 11:25 a.m., and 3:03 p.m., Resident 63 was observed sitting in a broda chair in his room. At those times, he was wearing oxygen per nasal cannula and the portable tank was set at 2.5 liters per minute. On 1/9/24 at 10:54 a.m., and 2:04 p.m., the resident was observed in bed and his oxygen tubing was not in his nares. On 1/11/24 at 8:05 a.m., the resident was observed sitting in the broda chair waiting for breakfast. The oxygen flow rate was set at 2.5 liters per the portable tank. The record for Resident 63 was reviewed on 1/10/24 at 3:30 p.m. Diagnoses included, but were not limited to, stroke, COPD, high blood pressure, kidney failure, and muscle weakness. The 10/8/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact, had no behaviors, and received oxygen. There was no Care Plan for the oxygen or if the resident refused to wear the oxygen. Physician's Orders, dated 8/1/23, indicated oxygen at 3 liters continuously via nasal cannula. During an interview on 1/11/24 at 8:50 a.m., LPN 2 indicated she normally checked the resident's oxygen when she administered his morning medications. She was unaware his portable concentrator was set at 2.5 liters per minute.		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.** 1 Residents 63 and 312 were assessed and were not affected by the alleged deficient practice. Rate was adjusted as ordered for both residents. 2 All residents, who require oxygen, have the potential to be affected by the same deficient practice. All residents, with oxygen orders, were observed to ensure that the oxygen was being delivered at the correct rate, prior to date of compliance 3 DON/Designee provided education to all Licensed Nurses regarding ensuring that all oxygen concentrators are set on the physician ordered rate. 4 DON/Designee will perform 5 random observations 3 x per week x 12 weeks to ensure that residents that are receiving oxygen are receiving it according to physician orders.	

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	01/12/2024

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
	During an interview with the Director of Nursing on 1/11/24 at 11:10 a.m., indicated the oxygen flow rate was to be set as ordered by the Physician. 2. On 1/8/24 at 11:06 a.m., Resident 312 was observed lying in bed. She was wearing oxygen at 3 liters via nasal cannula. On 1/9/24 at 2:11 p.m., the resident was observed sitting up in a chair watching tv, her nasal cannula was in place and the oxygen was on at 3 liters. On 1/10/24 at 10:05 a.m., the resident was observed in her room. The oxygen was being administered at 3 liters via nasal cannula. On 1/10/24 at 4:40 p.m., LPN 5 was observed administrating a nebulizer treatment. The LPN donned personal protective equipment (PPE) appropriately and then she poured the solution into the nebulizer casing. The nurse removed the resident's oxygen, which was on at 2 liters, and replaced it with a respiratory treatment mask. LPN 5 instructed and educated the resident to inhale and exhale slowly. At 4:50 p.m., the machine began to make a sputtering noise indicating the treatment was completed. The resident became antsy and asked why she was still wearing the mask when the treatment was completed. The LPN indicated to give it just a little bit longer, the treatment was not completed yet. The resident indicated she was feeling shaky and fatigued. At 4:54 p.m., the East Unit Manager was standing outside the resident's door and was asked to by the surveyor to assist LPN 5 with ending the treatment. The record for Resident 312 was reviewed on 1/09/24 at 4:06 p.m. The resident was admitted to the facility on 1/6/24. Diagnoses included, but		DON/designee will report all negative findings to monthly QAPI meeting for a period of 6 months.	

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	01/12/2024

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
	were not limited to, muscle weakness, anemia (low iron), chronic kidney disease, hypertension (high blood pressure), and shortness of breath. A Nursing Admission Evaluation Assessment, dated 1/6/24, indicated the resident was alert and oriented to person, place and time. The resident had clear speech and adequate hearing. A Physician's Order, dated 1/6/24, indicated to administer oxygen at 2 liters per nasal cannula continuously. A Physician's Order, dated 1/6/24, indicated to administer Ipratropium-Albuterol (respiratory medication) Inhalation Solution 0.5-2.5 milligrams (mg)/3 milliliters (ml) and to inhale orally four times a day. A Nurse's Progress Note, dated 1/1/24 at 9:38 a.m., indicated the resident was receiving oxygen at 2 liters per minute continuously. The Medication Administration Record (MAR) was reviewed and the oxygen order dated 1/6/24 was not transferred to the MAR. The oxygen was not signed out on 1/6/24, 1/7/24, 1/8/24, 1/9/24 and 1/10/24. A Policy titled, "Oxygen Medical Gas Use" with reviewed date 2/15/22, indicated ..."Will be monitored by licensed personnel for use and potential adverse side effects"... During an interview on 1/10/24 at 11:35 a.m., the East Unit Manager indicated the resident's oxygen was on at 3 liters, there was no additional information provided. During an interview on 1/11/24 at 9:48 a.m., the			

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	01/12/2024

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
	Director of Nursing (DON) indicated the nurse should have known when to stop the breathing treatment. 3.1-47(a)(6)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medication was labeled correctly, insulin bottles were not expired, and expired medication were discarded timely for 2 of 3 medication carts and 1 of 2 medication rooms.	F 0761	**F761** **Label/Store Drugs and Biologicals**	02/03/2024

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	01/12/2024

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
	(South and West Unit medication Carts, and the East Unit medication room) Findings include: 1. On 1/11/24 at 10:20 a.m., the East Unit Medication room was observed with LPN 3. Inside the top cabinet were 2 bottles of Tums with the order administration label visibly peeled off, there was a bottle of expired ear wax, dated 10/13/23, with administration details to administer for 14 days, there was an enema box, a bottle of deep sea nasal spray, and a bottle of polyethylene glycol (Miralax). During an interview on 1/11/24 at 10:24 a.m., LPN 3 indicated she was unsure why the medications were in the cabinet. Medications to be returned were to be placed in a bag and put into a bin located on the counter where they would get sent back to the pharmacy. 2. On 1/11/24 at 10:53 a.m., the South Unit Medication cart was observed with RN 2. The top drawer had a Nystatin tube with no label. During an interview on 1/11/24 at 11:03 a.m., RN 2 indicated she was unsure who the Nystatin cream belonged to. 3. On 1/11/24 at 11:11 a.m., the East Unit medication cart was observed with LPN 2. There was a multi use vial of Insulin with the date opened of 12/13/23 and a use by date of 1/10/24. There was a multi use vial of Lantus with a date opened of 12/5/23 and a use by date of 1/2/24. There was a multi use vial of Glargine Insulin with a date opened of 12/12/23 and a use by date of 1/9/24.		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.** 1 No Residents were affected by the alleged deficient practice. All appropriate medications have been destroyed per policy. 2 DON/designee observed all medication rooms and carts to ensure appropriate storage, prior to date of compliance. 1 DON/Designee provided education to all Licensed Nurses and Nurse Managers regarding ensuring that all expired medications are immediately removed from the medication rooms and medication carts. Licensed Nurses were also educated that any medication is use must have a resident name on it. 2 DON/Designee will perform observations 3 x per week x 12	

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	01/12/2024

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
	During an interview on 1/11/24 at 11:18 a.m., LPN 2 indicated she didn't realize the insulin vials were expired. During an interview on 1/11/24 at 11:31 a.m., the Director of Nursing (DON) indicated she understood the medication storage concerns and had no additional information to provide. 3.1-25(j) 3.1-25(o) 3.1-25(r)		weeks to ensure that there are not any expired medications in the medication rooms/carts and that all medication in the medication rooms/carts have a resident label on them. DON/designee will report all negative findings to monthly QAPI meeting for a period of 6 months.	
F 0880 SS=E 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;			

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	01/12/2024

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
	§483.80(a)(2) Written standards, policies, 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.			

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	01/12/2024

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
	§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 improper use of personal protective equipment (PPE) prior to entering and leaving a COVID-19 room, cleaning of reusable equipment, hand hygiene after direct resident contact and glove removal, and the storage of wash basins and tooth brushes for random observations of infection control. (Residents 264, 213, 63, and 12) Findings include: 1. On 1/10/24 at 9:47 a.m., Resident 264, who had COVID-19, had pressed his call light. The Admissions Director proceeded to the resident's room. Prior to entering the room, the Admissions Director donned an isolation gown, gloves, and an N95 mask. She did not don a face shield, which was available in the isolation bin, prior to entering the resident's room. A CNA took a cup of coffee to the resident's room and she knocked on the door. The Admissions Director opened the door to retrieve the coffee and she was not wearing a face shield or any other type of eye protection. When told by the East Unit Manager that she had to wear a face shield, the Admissions Director indicated that she didn't think she had to because she wasn't providing resident care.	F 0880	**F880** **Infection Prevention and Control** 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.** 1 Resident 264, 12 and 63 was assessed and was not affected by the alleged deficient practice. Resident 213 no longer resides in the facility. 2 DNS/designee completed an audit of all residents to verify that IC monitoring was in place. 3 DON/Designee provided education to all Facility Staff regarding: A Hand Hygiene should be performed before and after the	02/03/2024

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	01/12/2024

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
	2. On 1/10/24 at 11:05 a.m., LPN 4 was observed donning PPE prior to entering Resident 264's room. The resident had COVID-19. She donned an isolation gown, gloves, and an N95 mask. The LPN was wearing eyeglasses and she did not don a face shield or any other type of eye protection prior to entering the room. When exiting the resident's room, she was still wearing her N95 mask. The LPN proceeded down the hallway with her medication cart and entered another resident's room to answer a call light. At 11:19 a.m., the LPN continued to wear the N95 mask and she entered another resident's room, who was not COVID positive, to administer medication. During an interview with the Director of Nursing on 1/11/24 at 3:00 p.m., indicated a face shield should have been worn when in the room by both staff members and the nurse should have removed her N95 mask prior to leaving the COVID positive room. 3. During a random observation on 1/10/24 at 9:34 a.m., CNA 2 was observed cutting Resident 63's fingernails. After he was finished, he placed the nail clippers on the counter in the room and walked out of the lounge. At 9:36 a.m., the CNA was asked about Resident 12's fingernails being very long and dirty. The CNA indicated at that time, he thought some other CNA cut them, however, he would go look at them. He walked over to the resident and observed his fingernails and asked the resident if he could cut them, the resident did not refuse. The CNA retrieved the same clippers from the counter and trimmed his nails. During an Interview on 1/10/24 at 9:40 a.m., CNA 2 indicated he used the same nail clippers for		application and removal of gloves. B Nail clippers must be cleaned and sanitized in between resident use. C All PPE must be donned prior to entering resident rooms. D N95's are to be removed and discarded after exiting the COVID + rooms. E Hand hygiene must be performed before and after a resident assessment. F All wash basins and toothbrushes must be placed in plastic bags and stored in resident bathrooms. 4 DON/Designee will perform random observations on 3 residents 3 x per week x 12 weeks to ensure that Infection Prevention and Control practices are improving. DON/designee will report all negative findings to monthly QAPI meeting for a period of 6 months.	

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	01/12/2024

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
	Resident 12 that he used for Resident 63 without cleaning them in between residents. During an interview on 1/11/24 at 11:10 a.m., the Director of Nursing indicated the nail clippers should have been sanitized between residents. 4. During a random observation on 1/10/24 at 9:50 a.m., the NP (Nurse Practitioner) was observed performing an assessment on a female resident in front of the nurses' station. He touched the resident's legs and pressed on her abdomen with his bare hands, asked her a question and then walked into the lounge area. He did not perform hand hygiene. The NP proceeded to assess Resident 63 in the lounge in front of 2 other residents. He lifted up the resident's shirt and pressed on his abdomen with his bare hands. He then lifted up his pant leg and felt his calves with his bare hands. He took his stethoscope and placed it on the resident's bare abdomen and listened and then listened to his heart. He documented his findings on an IPad and then stood up and left the lounge area. The NP did not perform hand hygiene in between the residents or after he had finished the assessment of Resident 63. During an interview on 1/11/24 at 9:45 a.m., the Director of Nursing indicated the NP should have performed hand hygiene after he was finished with the assessment and in between residents. 5. On 1/11/24 at 8:10 a.m., the Wound Nurse was observed changing Resident 213's pressure ulcer bandages. The resident had 6 pressure ulcers and 5 of them were covered with bordered gauze bandages. The Wound Nurse washed her hands with soap and water prior to the treatment. She prepared the over bed table and placed her			

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	01/12/2024

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
	bandages and ointments on top of it. She donned a pair of clean gloves to both hands and removed the bandage from the right knee. She removed those gloves and donned a clean pair of gloves and cleaned the ulcer with wound cleanser. She removed those gloves, donned a clean pair of gloves to both hands, put the ointment on the bordered gauze sponge and placed it on the wound. She removed her gloves and donned a clean pair of gloves and proceeded to the left knee. The Wound Nurse did the same procedure as above for all the pressure ulcers without performing hand hygiene after glove removal and before donning a clean pair of gloves. During an interview on 1/11/24 at 8:45 a.m., the Wound Nurse indicated she did not perform hand hygiene after glove removal. During an interview 1/11/24 at 9:45 a.m., Director of Nursing (DON) indicated the Wound Nurse should have performed hand hygiene after glove removal. The current and updated 6/24/21 "Standard Precautions" policy, provided by the DON on 1/11/24 at 9:45 a.m., indicated hand hygiene should be performed after care between residents, after glove removal and after contact with inanimate objects (medical equipment). 6. During random observations on 1/8/24 at 10:43 a.m., 1/9/24 at 2:58 p.m., and 1/10/24 at 9:23 a.m., room 106 was observed with a pink wash basin on the floor under the sink and a clear plastic cylinder on the back of the toilet in the bathroom. Both the basin and cylinder were uncontained. There was 1 resident who used the bathroom. 7. During a random observation on 1/8/24 at 3:04			

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	01/12/2024

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
	p.m., room 105 was observed with a toothbrush behind the faucet on the bathroom sink and pink wash basin on the floor underneath the sink, both were not contained. There were 2 residents who used the bathroom. 8. During a random observation on 1/8/24 at 1:41 p.m., room 135 was observed with a pink wash basin on the floor in the bathroom. There were 2 residents who shared the bathroom. 3.1-18(b)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the kitchen area, as well as the residents' environment, was clean and in good repair related to an accumulation of rust, dirty baseboards, dirty floors, stained curtains, discolored floor tile, and urine odors in 1 of 1 kitchen areas and on 1 of 3 units. (The Main Kitchen and West Unit) Findings include: 1. During the Initial Kitchen Sanitation Tour on 1/8/24 at 9:13 a.m., with the Dietary Food Manager (DFM), the following was observed: A steel dish rack located in the dish room had an accumulation of rust along the edges. 2. During the Kitchen Sanitation Tour on 1/10/24 at 11:29 a.m. with the DFM, the following was observed:	F 0921	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 921 1 All affected areas were immediately addressed by housekeeping and maintenance department, to meet standard.	02/03/2024

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	01/12/2024

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
	a. An accumulation of dirt and debris was observed along the baseboard underneath the handwashing sink. b. An accumulation of dirt was observed along the baseboard underneath the steamer and extended to behind the oven. During an interview with the DFM on 1/12/24 at 11:20 a.m., indicated the dish rack was thrown away and the baseboards were in need of cleaning. 3. On 1/11/24 at 2:00 p.m., the following was observed on the West Unit during the Environmental Tour: a. Room 105 - there was dark brown debris around the faucet on the bathroom sink and an accumulation of dirt and debris along baseboard in bathroom. The base of the wall next to the closet was scratched and marred. There were 2 residents who resided in the room and used the bathroom. b. Room 110 - the floor tile in the room was cracked in areas in between the beds. There was no toilet paper holder in bathroom and the floor tile underneath bathroom sink was discolored. There was an accumulation of dirt along the baseboard in bathroom and the paint was cracked and peeling around the ceiling vent. There were 2 residents who resided in the room and used the bathroom. c. Room 115 - the tube feeding pole was rusted at the base. There was a bar of soap not contained laying directly on the white wooden rack in the bathroom. There were 2 residents who resided in the room and 2 resident share the bathroom.		2 ED/Designee conducted whole house environmental rounds prior to date of compliance. Any negative findings were immediately addressed. 3 ED/Designee has educated all kitchen, maintenance and environmental personnel on F 921, prior to date of compliance. 4 ED/Designee will audit the affected area 1 X per week X 12 weeks. ED/Designee 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.	

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	01/12/2024

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
	d. Room 135 - the privacy curtain was observed with red and orange stains and the window curtain was falling off the rod by the window. There were 2 residents who resided in the room. 4. During random observations on 1/8/24 at 10:43 a.m., 1/9/24 2:58 p.m., and on 1/10/24 at 9:23 a.m., the following was observed in Room 106: The floor beside the window was very dirty with dried food substance and debris. The room smelled like urine as well as the bathroom. The padded 1/4 side rails on the bed were torn and the there was a dried substance smeared on the rails. There was 1 resident in the room and used the bathroom. During an interview on 1/11/24 at 2:00 p.m., the Administrator indicated all of the above was in need of repair or cleaning. This citation relates to Complaints IN00417995 and IN00423615. 3.1-19(f)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment.	F 9999	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.	02/03/2024

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	01/12/2024

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
	This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure newly hired employees received a physical exam, and employees received annual resident rights training for 6 of 10 employee records reviewed. (QMA 1, RN 1, Activity Aide 1, BOM [Business Office Manager], LPN 1, and CNA 1) Findings include: 1. The employee files were reviewed on 1/11/24 at 10:00 a.m. The following employees lacked documentation of annual resident rights training: a. QMA 1, hired on 7/5/17 b. RN 1, hired on 5/17/06 2. The following newly hired employees lacked documentation of a physical exam. a. Activity Aide 1, hired on 11/14/23 b. BOM, hired on 11/20/23 c. LPN 1, hired on 9/18/23 d. CNA 1, hired on 11/8/23 During an interview on 1/12/24 at 1:25 p.m., the Human Resource Director indicated she had no additional information or documentation.		**The facility cordially requests paper compliance regarding alleged deficient practices.** F 9999 1 ED/Designee completed resident rights training with alleged deficient employees. The mentioned employees had a physical completed by appropriate medical staff prior to date of compliance. 2 ED/Designee completed an audit of all employee files to ensure resident rights and physicals were completed. 3 ED/designee completed education with HR manager to reflect the need for personnel files to have physicals and resident rights education prior to starting on the floor. 4 ED/Designee will audit the all new hires 1 X per week for 12 weeks to ensure resident rights have been educated on and physicals completed, prior to working on the floor.	