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	07/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00434347, IN00434492, IN00434589, IN00434592, IN00434642, IN00435075, IN00436341, IN00436847, IN00437410 and IN00437655. Complaint IN00434347 - No deficiencies related to the allegations are cited. Complaint IN00434492 - No deficiencies related to the allegations are cited. Complaint IN00434589 - No deficiencies related to the allegations are cited. Complaint IN00434592 - No deficiencies related to the allegations are cited. Complaint IN00434642 - No deficiencies related to the allegations are cited. Complaint IN00435075 - No deficiencies related to the allegations are cited. Complaint IN00436341 - Federal/State deficiencies related to the allegations are cited at F684 and F689. Complaint IN00436847 - No deficiencies related to the allegations are cited. Complaint IN00437410 - Federal/State deficiencies related to the allegations are cited at F580. Complaint IN00437655 - No deficiencies related to the allegations are cited. Survey dates: July 15 and 16, 2024	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.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Facility number: 000123 Provider number: 155218 AIM number: 100266720 Census Bed Type: SNF/NF: 114 Total: 114 Census Payor Type: Medicare: 2 Medicaid: 79 Other: 33 Total: 114 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/18/24.			
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. (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			

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	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) 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 promptly notify the resident's Power of Attorney (POA) of the onset of new non-pressure skin areas and a transfer to the hospital. The facility also failed to promptly notify the resident's physician of abnormal labs for 1 of 3 residents reviewed for non-pressure sores and 1 of 3 residents reviewed for a change in condition.	F 0580	**F580- 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	08/02/2024

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	(Resident E) Finding includes: The closed record for Resident E was reviewed on 7/15/24 at 12:40 p.m. The resident was admitted to the facility on 12/29/23 and discharged to the hospital on 6/13/24. Diagnoses included, but were not limited to, stroke, hemiplegia, heart disease, dysphagia (swallowing difficulties), peg tube (a tube inserted directly into the stomach for nutrition), chest pain, high blood pressure, and vascular dementia. The 5/9/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. The resident had a limited range of motion with impairment to one side for both upper and lower extremities, and was dependent on staff for toilet hygiene, showers, and baths. The resident was at risk for developing pressure ulcers and currently had pressure ulcers. A Wound Nurse Practitioner (NP) Progress Note, dated 3/4/24, indicated the resident had developed moisture associated skin damage (MASD) to the right lower buttock. A treatment was ordered to care for the non-pressure wound. A Wound NP Progress Note, dated 3/11/24, indicated the resident acquired a left medial knee skin tear. There was no documentation the resident's POA was notified of the new skin conditions. A Nursing Progress Note, dated 3/9/24 at 12:34 p.m., indicated the resident was observed with redness and a fluid-filled blister on the upper right		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 E is no longer in the facility. 2 All residents, who have a non-pressure area, are transferred to the Emergency room or have abnormal labs, have the potential to be affected by the same deficient practice. All residents who have had any change of condition over the past week have had their medical record evaluated to ensure appropriate resident family notification. 3 DON/Designee has educated Licensed Nurses on the importance of ensuring that all residents who have had any change of condition, have the required family notification performed. 4 DON/Designee will audit 5 random residents weekly X 4 weeks, than 5 residents monthly X 5 months with a change of condition, to ensure appropriate	

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	outer thigh. There was no documentation the resident's POA was notified of the fluid filled blister. A Nursing Progress Note, dated 3/11/24 at 1:38 p.m., indicated the resident was observed with a small lump on the left side of her forehead that was tender to touch. A Nursing Progress Note, dated 3/12/24 at 1:00 p.m., indicated the resident's family was updated on resident's lump to the forehead. This was the first documented entry the family was notified of the lump. A NP Progress Note, dated 6/7/24, indicated the resident had a right gluteal wound infection and the plan was to start IV (intravenous) Vancomycin (an antibiotic) and Levaquin (an antibiotic) through the peg tube. A weekly Complete Blood Count (CBC) and a Complete Metabolic Panel (CMP) were to be drawn for laboratory work. Nurses' Notes, dated 6/7-6/9/24, indicated a PICC (a peripheral inserted central catheter) line was not able to be placed. A Nurses' Note, dated 6/10/24 at 5:58 p.m., indicated the resident was sent out to hospital for the PICC line insertion. There was no documentation the resident's POA was notified of the transfer. A CBC, collected on 6/11/24 and received by the facility at 3:13 p.m., indicated the resident had abnormal labs as follows: - White Blood Cells were 13.08 a high value (normal range 4.8-10.8)		family notification has been performed. DON/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	- Hemoglobin was 11.1 a low value (normal range 12-16) - Neutrophils were 10.29 a high value (normal range 1.40-6.8) A CBC, collected on 6/7/24, indicated the White Blood Cells were 10.19. The NP did not review the abnormal labs until 6/12/24 at 3:37 p.m. (over 24 hours). There was no documentation in nursing progress notes to indicate the NP was notified of the abnormal labs. During an interview on 7/16/24 at 1:55 p.m., the Director of Nursing (DON) indicated there was no documentation the resident's family was notified of all the non-pressure areas, the lump on the forehead, and the transfer to ER for the PICC line insertion. The NP did not review the abnormal labs until 24 hours later. The current and undated "Notification of Change in Condition" policy, provided by the DON indicated the center must inform the resident, consult with the resident's physician and/or notify the residents' representative, authorized family member, or legal POA or guardian when there was a change requiring notification. Circumstances requiring notification, included but were not limited to, a transfer or discharge of the resident from the center, a need to alter treatment and a significant change in the resident's physical condition. This citation relates to Complaint IN00437410. 3.1-5(a)(2) 3.1-5(a)(3) 3.1-5(a)(4)			

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to initiate neurological checks after an unwitnessed fall for 1 of 3 residents reviewed for falls. (Resident D) Finding includes: The record for Resident D was reviewed on 7/16/24 at 8:15 a.m. The resident was admitted to the facility on 4/24/24. Diagnoses included, but were not limited to, stroke, dysphagia (swallowing difficulties), peg tube (a tube inserted directly into the stomach for nutrition), hemiplegia, type 2 diabetes, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 5/1/24, indicated the resident was not cognitively intact for daily decision making. The resident was dependent on staff for toilet hygiene and had an indwelling foley (urinary) catheter. The resident had no history of falls while at the facility. A Care Plan, dated 4/26/24, indicated the resident was at risk for falls. A nursing approach was to ensure the resident was wearing appropriate non-skid footwear.	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.** 1 Resident D was assessed and was not affected by the alleged deficient practice. 2 All residents who have had an unwitnessed fall in the last 30 days have been assessed to ensure that there were no adverse effects related to the alleged deficient practice. No adverse effects were noted.	08/02/2024

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	A Care Plan, dated 5/2/24, indicated the resident had a behavior problem of intentionally throwing his legs on the side of the bed, increasing his risk for falls. A Nurses' Note, dated 5/28/24 at 3:58 p.m., indicated a CNA had walked by the resident's room and the resident was observed on the floor. The resident was sent out to the emergency room for further testing and returned back on 5/29/24 at 3:37 a.m. An IDT (Interdisciplinary Team) Fall Follow Up, dated 5/30/24 at 12:02 p.m., indicated the resident was last observed in bed and then was observed on the floor in his room. There were no neurological checks initiated at the time of the fall or after the resident returned from the hospital. Nurses' Note, dated 6/10/24 at 7:32 a.m., indicated the resident was observed on the floor in his room. An IDT Fall Follow Up, dated 6/10/24 at 2:34 p.m., indicated the resident had a fall on 6/10/24. The resident was in bed in his room and was observed violently shaking, which caused him to change his position in bed. During an interview on 7/16/24 at 1:55 p.m., the Director of Nursing indicated there were no neurological checks completed after the fall on 5/28/24 and the staff had informed her the 6/10/24 fall was witnessed. The current and undated "Neurological Checks" policy provided by the DON on 7/16/24 at 2:46 p.m., indicated neurological checks should be		3 DON/Designee has educated Licensed Nurses on the policy and procedure for unwitnessed falls, specific to the neuro check expectation. 4 DON/Designee will audit all falls to ensure policy and procedure was followed. Audits will be conducted 3 X per week for 6 months. Audits will be reviewed in month QAPI meeting until 95% compliance is achieved. Any negative findings will be immediately addressed.	

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	performed for falls with unknown head injury. This citation relates to Complaint IN00436341. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a resident with a history of falls was wearing the proper footwear to prevent further falls and/or injury for 1 of 3 residents reviewed for falls. (Resident D) Finding includes: During a random observation on 7/16/24 at 8:00 a.m., Resident D was observed sitting in a geri recliner with both feet elevated. At that time, he was observed wearing plain black ankle socks to both feet. During random observations on 7/16/24 at 10:05 a.m. and 11:30 a.m., the resident was observed lying in bed. At those times, he was wearing plain black ankle socks to both feet. The record for Resident D was reviewed on 7/16/24 at 8:15 a.m. The resident was admitted to the facility on 4/24/24. Diagnoses included, but	F 0689	**689** **The facility cordially requests paper compliance regarding alleged deficient practices.** 1 Resident D was assessed and was not affected by the alleged deficient practice. Resident D was immediately assisted with placing on non-skid socks. 2 All residents, who have a history of falls and a care plan for non-skid footwear, have had their care plans evaluated and the residents were assessed to ensure that their non-skid footwear were in place.	08/02/2024

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	were not limited to, stroke, dysphagia (swallowing difficulties), peg tube (a tube inserted directly into the stomach for nutrition), hemiplegia, type 2 diabetes, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 5/1/24, indicated the resident was not cognitively intact for daily decision making. The resident was dependent on staff for toilet hygiene and had an indwelling foley (urinary) catheter. The resident had no history of falls while at the facility. A Care Plan, dated 4/26/24, indicated the resident was at risk for falls. A nursing approach was to ensure the resident was wearing appropriate non-skid footwear. A Care Plan, dated 5/2/24, indicated the resident had a behavior problem of intentionally throwing his legs on the side of the bed, increasing his risk for falls. A Nurses' Note, dated 5/28/24 at 3:58 p.m., indicated a CNA had walked by the resident's room and the resident was observed on the floor. The resident was sent out to the emergency room for further testing and returned back on 5/29/24 at 3:37 a.m. An IDT (Interdisciplinary Team) Fall Follow Up, dated 5/30/24, at 12:02 p.m., indicated the resident was last observed in bed and then was observed on the floor in his room. Nurses' Note, dated 6/10/24 at 7:32 a.m., indicated the resident was observed on the floor in his room. An IDT Fall Follow Up, dated 6/10/24 at 2:34 p.m.,		3 DON/Designee has educated Nursing Staff on the importance of ensuring that all residents who have a history of falls and have a care plan for non-skid footwear are wearing their non-skid footwear. 4 DON/Designee will audit 5 random residents with a history of falls and a care plan for non-skid footwear 3 X per week for 4 weeks, 1 X per week for 8 weeks than monthly for 3 months, to ensure that non-skid footwear is in place. DON/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved. ="" b="">	

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	indicated the resident had a fall on 6/10/24. The resident was in bed in his room and was observed violently shaking, which caused him to change his position in bed. A grievance, filed by the resident's spouse and dated 5/28/24, indicated the ambulance service had left the resident alone in his room and in bed and did not tell staff that he had returned. The resident then fell out of bed. The resolution for the concern was to educate staff and monitor ongoing staff performance. During an interview on 7/16/24 at 1:55 p.m., the Director of Nursing indicated the resident was supposed to have appropriate footwear on at all times. This citation relates to Complaint IN00436341. 3.1-45(a)(2)			