

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

PRINTED: 05/14/2024  
FORM APPROVED  
OMB NO. 0938-039

|   |   |   |  |   |  |  |                            |
|---|---|---|--|---|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br><br>155218 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                        |  | X3) DATE SURVEY<br>COMPLETED<br>04/23/2024 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREAT LAKES HEALTHCARE CENTER |   |   |  | STREET ADDRESS, CITY, STATE, ZIP COD<br>2300 GREAT LAKES DR<br>DYER, IN 46311 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIE<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |   |  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE |
| F 0000<br><br>Bldg. 00  | <p>This visit was for the Investigation of Complaints IN00428543, IN00429320, IN00429834, and IN00430986.</p> <p>Complaint IN00428543 - Federal/State deficiencies related to the allegations are cited at F661.</p> <p>Complaint IN00429320 - Federal/State deficiencies related to the allegations are cited at F558, F584, F677, and F686.</p> <p>Complaint IN00429834 - Federal/State deficiencies related to the allegations are cited at F558, F584, F677, and F686.</p> <p>Complaint IN00430986 - Federal/State deficiencies related to the allegations are cited at F559.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: April 22 &amp; 23, 2024</p> <p>Facility number: 000123<br/>Provider number: 155218<br/>AIM number: 100266720</p> <p>Census Bed Type:<br/>SNF/NF: 115<br/>Total: 115</p> <p>Census Payor Type:<br/>Medicare: 10<br/>Medicaid: 78<br/>Other: 17<br/>Total: 115</p> <p>These deficiencies reflect State Findings cited in</p> |   |  | F 0000  | <p>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.</p> <p><b>The facility cordially requests paper compliance regarding alleged deficient practices.</b></p> |  |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Jason Eastlund

Executive Director

05/10/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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 disclosable 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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| F 0558<br>SS=D<br>Bldg. 00  | <p>accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on 4/26/24.</p> <p>483.10(e)(3)<br/>Reasonable Accommodations<br/>Needs/Preferences<br/>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.</p> <p>Based on observation, record review, and interview, the facility failed to meet residents' needs related to a call light not placed within reach for 2 of 7 residents observed for call light placement. (Residents G and K)</p> <p>Findings include:</p> <p>1. During an observation on 4/22/24 at 9:52 a.m., Resident G was lying in bed with the head of the bed up and his breakfast tray sitting in front of him on the over the bed table. The call light was draped over the bedside dresser on the right side of the bed and was out of reach of the resident.</p> <p>During an observation on 4/22/24 at 10 a.m., CNA 3 and CNA 4 entered the room, and removed the meal tray. The call light remained draped over the bedside dresser.</p> <p>During an observation on 4/22/24 at 10:10 a.m., the call light remained draped over the bedside dresser.</p> <p>During an observation on 4/22/24 at 10:22 a.m., CNA 3 and CNA 4 entered the room. They</p> |  |  | F 0558  | <p>1 Resident G and Resident K were not harmed by the alleged deficient practice. Residents were assessed and were not noted with any adverse effects related to the alleged deficient practice.</p> <p>2 ED/Designee completed 100% audit of all call lights to ensure they were in place and appropriately fastened to the bed.</p> <p>3 ED/Designee has educated all facility staff on call light policy, specific to it being within in a residents reach.</p> <p>4 ED/Designee will conduct random call light observations on 5 residents 3 x weekly to ensure that all call lights are within the reach. ED/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. The IDT will</p> |  | 05/10/2024                 |

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|   | <p>indicated they had been checking on the resident every one to two hours. After repositioning the resident, CNA 4 placed the call light within reach of the resident. CNA 3 indicated at the time of the observation the resident would not have been able to reach the call light when it was draped over the bedside dresser.</p> <p>Resident G's record was reviewed on 4/22/24 at 11:54 a.m. The diagnoses included, but were not limited to, cerebrovascular insufficiency and dementia.</p> <p>A Quarterly Minimum Data Set assessment, dated 2/12/24, indicated a moderately impaired cognitive status, impairment of the bilateral lower extremities, was dependent for bed mobility and transfers, and has had a history of falls and one fall since the last assessment.</p> <p>A Care Plan, revised on 2/1/24, indicated a risk for falls and actual falls had occurred. An intervention, dated 8/14/23, indicated the call light would be within reach of the resident.</p> <p>2. During an observation on 4/22/24 at 9:42 a.m., Resident K was lying in bed with her eyes closed. The breakfast tray was on the over the bed table in front of her. The call light was tied to the side rail, and hanging down toward the floor and not within reach for the resident.</p> <p>During an observation on 4/22/24 at 10:12 a.m., the meal tray had been removed. The head of the bed remained elevated. The call light continued to be out of reach from the resident and was hanging down from the side rail on the bed.</p> <p>During an observation on 4/22/24 at 10:34 a.m.,</p> |   |  |   | determine if the audits are necessary to continue after 6 months with 100% compliance achieved.                          |  |                            |

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| F 0559<br>SS=D<br>Bldg. 00  | <p>Resident K received incontinent care by CNA 5. The call light was placed within reach to the resident.</p> <p>This citation is related to Complaints IN00429320 and IN00429834.</p> <p>3.1-35(b)(1)</p> <p>483.10(e)(4)-(6)<br/>Choose/Be Notified of Room/Roommate Change<br/>§483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.</p> <p>§483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.</p> <p>§483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.</p> <p>Based on record review and interview, the facility failed to notify the resident and/or the resident's Responsible Party in writing of an intrafacility transfer related to changing rooms due to a COVID-19 outbreak for 3 of 3 residents reviewed for infection control. (Residents D, M, N)</p> <p>Findings include:</p> <p>1. During an interview on 4/22/24 at 11:14 a.m., Resident D indicated he was moved to a different room when he had COVID-19. He was in the other room for 20 days and they kept telling him he was</p> |   |  | F 0559  | <p>1 Residents D, M, and N met with social services and showed no symptoms of psychosocial distress from the alleged deficient practice.</p> <p>2 All residents, who transferred in the facility, 2 weeks prior to date of compliance, were audited to ensure intra-facility transfers were completed.</p> |  | 05/10/2024                 |

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|   | <p>going to move back "tomorrow."</p> <p>The record for Resident D was reviewed on 4/22/24 at 12:18 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) hemiplegia, stroke, heart failure, venous insufficiency, vascular dementia, anxiety disorder, and chronic kidney disease.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 2/16/24, indicated the resident was cognitively intact for daily decision making.</p> <p>Nurses' Notes, dated 3/20/24 at 11:33 a.m., indicated the resident had tested positive for COVID-19 that morning.</p> <p>Nurses' Notes, dated 3/20/24 at 11:34 a.m., indicated the resident and Guardian were made aware of the room change and had no questions or concerns at the time.</p> <p>The resident was transferred back to the original room on 4/7/24. There was no documentation regarding the move back in the clinical record.</p> <p>There was no documentation of an intrafacility transfer form for the move to another room when the resident had tested positive for COVID-19.</p> <p>During an interview on 4/22/24 at 3:15 p.m., the Director of Nursing indicated there was no intrafacility transfer form for the resident when he had moved to a different room when he tested positive for COVID-19. 2. The record for Resident M was reviewed on 4/23/24 at 9:10 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and chronic kidney disease.</p> |   |  |  | <p>3 ED/Designee has educated all licenses nurses and social services department, that when a resident transfers with-in the facility, the intra-facility transfer form must be completed.</p> <p>4 Administrator/Designee will all audit all intra-facility transfers to ensure that the appropriate form is completed with every room transfer. ED/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.</p> |  |                            |

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|   | <p>The Quarterly Minimum Data Set (MDS) assessment, dated 4/12/24, indicated the resident had impaired short term and long term memory and severely impaired cognitive decision making skills.</p> <p>A Progress Note, dated 3/15/24 at 12:58 p.m., indicated the resident had tested positive for COVID-19, was on droplet isolation precautions, and was to reside on the quarantine unit in a room alone.</p> <p>The census tab of the chart indicated the resident was moved from room 112 B to room 124 A on 3/15/24.</p> <p>The was a lack of an intra-facility transfer form or documentation of a room change notification.</p> <p>During an interview with the Social Service Director on 4/23/24 at 11:07 a.m., she indicated she had not completed a notification of room change form. The resident had changed rooms due to being COVID positive.</p> <p>3. The record for Resident N was reviewed on 4/23/24 at 9:10 a.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, and coronary artery disease.</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 4/8/24, indicated the resident was cognitively intact.</p> <p>A Progress Note, dated 3/15/24 at 12:57 p.m., indicated the resident had tested positive for COVID-19, was on droplet isolation precautions, and was to reside on the quarantine unit in a room alone.</p> |   |  |   |  |  |                            |

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| F 0584<br>SS=D<br>Bldg. 00  | <p>The census tab of the chart indicated the resident was moved from room 228 A to room 103 A on 3/15/24.</p> <p>The was a lack of an intra-facility transfer form or documentation of a room change notification.</p> <p>During an interview with the Social Service Director on 4/23/24 at 11:07 a.m., she indicated she had not completed a notification of room change form. The resident had changed rooms due to being COVID positive.</p> <p>This citation relates to Complaint IN00430986.</p> <p>3.1-3(v)(2)</p> <p>483.10(i)(1)-(7)<br/>Safe/Clean/Comfortable/Homelike Environment<br/>§483.10(i) Safe Environment.<br/>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide-<br/>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br/>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br/>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> |   |  |   |  |  |                            |

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|   | <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2) (iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>Based on observation and interview, the facility failed to ensure a clean and homelike environment, related to stained, dirty, and tattered bed linens for 3 of 6 residents reviewed for a homelike environment. (Residents D, C, and H)</p> <p>Findings include:</p> <p>1. During an observation on 4/22/24 at 11:14 a.m., Resident D was sitting up in a wheelchair at the bedside. He had requested to be transferred back to bed after his bed was made. His bed had been stripped and two CNAs entered the room and made the bed. There was a hole in the bottom sheet that had been placed on the bed. The CNAs transferred the resident to bed after the bed was made and left the room.</p> |   |  | F 0584  | <p>state law.</p> <p><b>The facility cordially requests paper compliance regarding alleged deficient practices.</b></p> <p>1 Resident C and D immediately had their bedding changed.</p> <p>2 ED/Designee completed 100% audit on all bedding to ensure no holes or stains were on them. Any negative findings were immediately addressed.</p> <p>3 ED/Designee has educated all facility staff that any bedding with holes or stains, should be</p> |  | 05/10/2024                 |

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|   | <p>During an observation on 4/23/24 at 10:10 a.m., the bottom sheet with hole in the sheet remained on the resident's bed.</p> <p>2. During an observation on 4/22/24 at 3:48 p.m., Resident J was lying in bed with the head of the bed slightly elevated. There were two pillows under the resident's head. There was a brownish/tan dried stain on the pillow case of the bottom pillow.</p> <p>3. During an observation on 4/23/24 at 7:55 a.m., Resident C was lying in bed with the head of the bed elevated. There was an orange stain on the pillow case under her head. Resident C indicated she would like to be repositioned in bed and activated the call light. Wound Nurse 1 and the Unit Manager entered the room and began to reposition the resident. When the pillow was removed from under the right leg, a dried tan stain was observed on the pillow case. Wound Nurse 1 indicated the dressing on the right lower leg was intact and she was unsure what the dried tan stain was from. They turned the resident to the right side. An incontinent brief was worn by the resident and intact. The pressure dressing and wound vacuum dressings on the buttocks were intact. There were large dried beige stains on the bottom sheet under the resident. The Unit Manager indicated the staff had not been in the room for the morning care yet. No further information was received from the Unit Manager when asked if the sheets should have been changed during the night when they repositioned and checked the resident.</p> <p>During an interview with the resident at the time of the observation, she indicated no one had been her room all night.</p> |   |  |  | <p>dealt with appropriately.</p> <p>4 ED/Designee will conduct random bed observations on 5 residents 3 x weekly to ensure that there are not any holes or stains in the resident bed sheets. Administrator/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.</p> |  |                            |

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OMB NO. 0938-039

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br><br>155218 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                        |  | X3) DATE SURVEY<br>COMPLETED<br>04/23/2024 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREAT LAKES HEALTHCARE CENTER |   |   |  | STREET ADDRESS, CITY, STATE, ZIP COD<br>2300 GREAT LAKES DR<br>DYER, IN 46311 |  |  |                            |
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| F 0661<br>SS=D<br>Bldg. 00  | <p>During an interview on 4/23/24 at 8:25 a.m., the Administrator indicated if the linens were soiled, they should have been changed.</p> <p>During an interview on 4/23/24 at 1:20 p.m., the Administrator indicated the facility has ordered 16 dozen new sheets, both tops and fitted. If the linen was tattered, they were to be thrown out and replaced, as there was plenty of linen to replace the stained and tattered linen.</p> <p>This citation relates to Complaints IN00429320 and IN00429834.</p> <p>3.1-19(f)(5)<br/>3.1-19(g)(4)</p> <p>483.21(c)(2)(i)-(iv)<br/>Discharge Summary<br/>§483.21(c)(2) Discharge Summary<br/>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:<br/>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.<br/>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.<br/>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).<br/>(iv) A post-discharge plan of care that is</p> |   |  |   |  |  |                            |

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|   | <p>developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p> <p>Based on record review and interview, the facility failed to ensure a recapitulation of the resident's stay was documented on the discharge summary provided to the resident at the time of discharge for 3 of 3 residents reviewed for discharge. (Residents B, E, and F)</p> <p>Findings include:</p> <p>1. The record for Resident B was reviewed on 4/22/24 at 9:53 a.m. Diagnoses included, but were not limited to, high blood pressure, atrial fibrillation, heart disease, heart failure, adult failure to thrive, hallucinations, and anemia.</p> <p>The Modification of the Quarterly Minimum Data Set (MDS) assessment, dated 1/10/24, indicated the resident was moderately impaired for daily decision making.</p> <p>Physician's Orders, dated 3/21/22, indicated may discharge to an assisted living facility on 3/22/24.</p> <p>The Discharge Summary, dated 3/19/24, indicated the "Course of illness/Progress (include any complications experienced)" had "N/A" documented in the space.</p> <p>There was no documentation of a recapitulation of the resident's stay on the discharge summary.</p> |   |  | F 0661  | <p><b>The facility cordially requests paper compliance regarding alleged deficient practices.</b></p> <p>1 Resident B, E and F have discharged from the facility.</p> <p>2 All residents, who discharge from the facility, 2 weeks prior to date of compliance, were reviewed to identify recapitulation was documented in the discharge summary.</p> <p>3 DON/Designee has educated all Licensed Nurses that when a resident discharge from the facility, that the recapitalization must be completed prior to discharging the resident.</p> <p>4 DON/Designee will all audit all discharges to ensure that the recapitalization is completed on all facility discharges. DON/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. The IDT will</p> |  | 05/10/2024                 |

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|   | <p>During an interview on 4/22/24 at 3:25 p.m., the Director of Nursing indicated she was unaware the nursing staff were documenting "N/A" under the course of stay. The Discharge Summary was to be completed and was given to the resident at the time of discharge.</p> <p>2. The record for Resident E was reviewed on 4/22/24 at 10:53 a.m. Diagnoses included, but were not limited to, fracture of the left radius, high blood pressure, uterine cancer, and major depressive disorder. The resident was discharged to an assisted living facility on 4/19/24.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 4/2/24, indicated the resident was moderately impaired for decision making.</p> <p>Physician's Orders, dated 4/17/24, indicated may discharge to assistant living facility on Friday 4/19/24.</p> <p>The Discharge Summary, dated 4/15/24, indicated the "Course of illness/Progress (include any complications experienced)" had "N/A" documented in the space.</p> <p>There was no documentation of a recapitulation of the resident's stay on the discharge summary.</p> <p>There was no documentation in Nursing Progress Notes at the time of discharge on 4/19/24.</p> <p>During an interview on 4/22/24 at 3:25 p.m., the Director of Nursing indicated she was unaware the nursing staff were documenting "N/A" under the course of stay. The Discharge Summary was to be completed and was given to the resident at the time of discharge. There was no</p> |   |  |   | determine if the audits are necessary to continue after 6 months with 100% compliance achieved.                          |  |                            |

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|   | <p>documentation in Nursing Notes at the time the resident discharged.</p> <p>3. The record for Resident F was reviewed on 4/22/24 at 11:14 a.m. Diagnoses included, but were not limited to, fracture lower leg, high blood pressure, depressive disorder, and mild intellectual disabilities.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 1/29/24, indicated the resident was cognitively impaired for daily decision making.</p> <p>Physician's Orders, dated 3/11/24, indicated may discharge home on Wednesday 3/13/24 with home health.</p> <p>The Discharge Summary, dated 3/11/24, indicated the Nursing section where the "Course of illness/Progress (include any complications experienced)" was located was blank and not completed.</p> <p>During an interview on 4/22/24 at 3:25 p.m., the Director of Nursing indicated the Discharge Summary was to be completed at the time of discharge and given to the resident.</p> <p>The current and undated "Transfer and Discharge" policy, provided by the Administrator on 4/23/24 at 10:51 a.m., indicated when a resident was discharged to home, assisted living, or another long term care facility was anticipated, the facility will develop a discharge summary that included, but was not limited to, the following: Summary of Stay-a summary of the resident's stay that included diagnosis, course of illness/treatment or therapy, pertinent labs, radiology, and consultation results.</p> |   |  |   |  |  |                            |

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| F 0677<br>SS=D<br>Bldg. 00  | <p>This citation refers to Complaint IN00428543</p> <p>3.1-36(a)(1)</p> <p>483.24(a)(2)</p> <p>ADL Care Provided for Dependent Residents</p> <p>§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;</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents who were dependent and/or required assistance with activities of daily living (ADL's) received assistance with their meals, for 2 of 6 residents reviewed for ADL's. (Residents L and C)</p> <p>Findings include:</p> <p>1. During a random observation on 4/22/24 at 1:00 p.m., CNA 1 delivered a lunch tray to Resident L. The CNA placed the tray on the over bed table and left the room.</p> <p>At 1:13 p.m., 1:23 p.m. and 1:30 p.m., the tray remained in the same place, untouched, and the resident had not been assisted to eat.</p> <p>During an interview on 4/22/24 at 1:30 p.m., CNA 1 indicated she delivered the tray to the resident who was asleep at the time, and asked her if she was ready to eat. The resident told staff she was not ready to eat, so the tray was left on the over bed table. The CNA indicated she was going to check on the resident to see if she was ready to eat before she left for the day at 2:00 p.m. She was unaware that no other staff had been in the room to see if the resident was ready to eat and if she</p> |   |  | F 0677  | <p>1 Resident was not harmed by the alleged deficient practice. Resident L and C were assessed and no adverse effects related to the alleged deficient practices were noted.</p> <p>2 All residents who require assistance with meals, were reviewed to ensure appropriate interventions were put into place</p> <p>3 DON/Designee has educated all facility staff that if residents are dependent and/or require assistance with ADL's, they should receive assistance with set up and/or eating meals.</p> <p>4 DON/Designee will conduct random observations, during meal times, on 5 residents, 3 x weekly to ensure that staff are assisting those residents that require assistance with meals. Administrator/Designee will report on audits monthly to the</p> |  | 05/10/2024                 |

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|   | <p>needed assistance.</p> <p>The record for Resident L was reviewed on 4/23/24 at 9:15 a.m. The resident was admitted to the facility on 4/11/24. Diagnoses included, but were not limited to, dysphagia, stroke, aphasia depressive disorder, anxiety disorder, bipolar disorder, sepsis, cerebral edema, and high blood pressure.</p> <p>A Nursing Admission Assessment, dated 4/11/24, indicated the resident was alert and oriented to person, place, and time.</p> <p>A Functional Abilities and Goals Assessment, dated 4/14/24, indicated the resident needed partial to moderate assistance with the task of eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal was placed before the resident).</p> <p>In the task section for eating, the resident was coded as being dependent for 15 meals served and independent with eating for 9 meals served.</p> <p>During an interview on 4/22/25 at 3:15 p.m., the Director of Nursing indicated the CNA had informed her about the time lapse of her lunch tray being in the room and that no staff had gone back into feed her. The DON indicated the CNA said she was asleep and did not want to eat at that time.</p> <p>During an interview on 4/23/24 at 8:00 a.m., the resident indicated she does need assistance with eating at times.</p> <p>2. During an observation on 4/22/24 at 12:59 p.m., the lunch meal was delivered to Resident C's</p> |   |  |   | <p>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.</p> |  |                            |

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|   | <p>room, and placed on the shelf in the room, due to care was just being completed on the resident.</p> <p>At 1:02 p.m., CNA 2 offered the meal and Resident C indicated she wanted to wait until her treatments were completed before she ate her meal. Wound Nurse 1 and the Wound Nurse Practitioner then completed the treatments for the resident's pressure areas.</p> <p>During an observation on 4/22/24 at 2:13 p.m., Resident C was lying in bed with the head of the bed elevated. The meal tray was on her over the bed table in front of her. She had consumed the baked beans and California blend vegetable. The smoked sausage, which was approximately four inches long and a quarter size around, was untouched on the plate. Resident C indicated she wanted to eat the sausage but was unable to cut it up by herself to eat it. The Director of Nursing (DON) was interviewed immediately after the observation, and indicated she would get a staff member to come and cut the sausage up for the resident.</p> <p>Resident C's record was reviewed on 4/22/24 at 1:17 p.m. The diagnoses included, but were not limited to, multiple sclerosis.</p> <p>An Admission Minimum Data Set assessment, dated 2/21/24, indicated a moderately impaired cognitive status, no behaviors, impairment of the bilateral upper extremities, and required supervision/set-up for eating.</p> <p>A Care Plan, dated 2/23/24, indicated a potential for an altered nutritional status. The interventions included the staff would provide assistance with the meals as needed.</p> <p>This citation relates to Complaints IN00429320</p> |   |  |   |  |  |                            |

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| F 0686<br>SS=D<br>Bldg. 00  | <p>and IN00429834.</p> <p>3.1-38(a)(3)</p> <p>483.25(b)(1)(i)(ii)<br/>Treatment/Svcs to Prevent/Heal Pressure<br/>Ulcer</p> <p>§483.25(b) Skin Integrity<br/>§483.25(b)(1) Pressure ulcers.<br/>Based on the comprehensive assessment of<br/>a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with<br/>professional standards of practice, to prevent<br/>pressure ulcers and does not develop<br/>pressure ulcers unless the individual's clinical<br/>condition demonstrates that they were<br/>unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives<br/>necessary treatment and services, consistent<br/>with professional standards of practice, to<br/>promote healing, prevent infection and prevent<br/>new ulcers from developing.</p> <p>Based on observation, record review, and<br/>interview, the facility failed to ensure a resident<br/>with pressure ulcers received the necessary<br/>treatment and services to promote healing, related<br/>to dressings not present as ordered by the<br/>Physician, for 1 of 3 residents reviewed for<br/>pressure ulcers. (Resident C)</p> <p>Finding includes:</p> <p>During an observation on 4/22/24 at 8:27 a.m.,<br/>Resident C was lying in bed. CNA 2 and CNA 7<br/>entered the room to provide repositioning and<br/>check for incontinence. The incontinent brief was<br/>undone and the resident was rolled onto her left<br/>side. The pressure area on the sacrum/coccyx area<br/>had foam inside of the area and the wound</p> |   |  | F 0686  | <p><b>The facility cordially requests<br/>paper compliance regarding<br/>alleged deficient practices.</b></p> <p>1 Resident C was assessed<br/>and was not noted with any<br/>adverse effects related to the<br/>alleged deficient practice.</p> <p>2 All residents, with pressure<br/>ulcer treatments, have been<br/>reviewed to ensure MD orders are<br/>followed related to pressure ulcer<br/>dressings.</p> <p>3 DON/Designee have<br/>educated all Licensed Nurses that</p> |  | 05/10/2024                 |

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|   | <p>vacuum was not in place. There was no dressing covering the area. The pressure area on the left ischium had no dressing covering it, and there was no dressing on the right ischium pressure ulcer. CNA 2 indicated he started his shift at 6:30 a.m. and the resident was last checked by him, there were no dressings on the pressure wounds. CNA 7 indicated the dressings were on the resident on 4/21/24 during the day shift.</p> <p>During an interview on 4/22/24 at 1:02 p.m., Wound Nurse 1 and the Wound Nurse Practitioner indicated sometimes when the resident was soiled, the pressure dressings would be removed. They indicated no one had reported to them the pressure dressings were not in place.</p> <p>Resident C's record was reviewed on 4/22/24 at 1:17 p.m. The diagnoses included, but were not limited to, multiple sclerosis.</p> <p>An Admission Minimum Data Set assessment, dated 2/21/24, indicated a moderately impaired cognitive status, no behaviors, impairment of the bilateral upper and lower extremities. She required maximum assistance with toileting and bed mobility, was dependent for transfers and showers, and had an indwelling urinary catheter and was frequently incontinent of bowel movement. She was admitted into the facility with two stage four pressure ulcers (full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) and two unstageable pressure ulcers (pressure ulcer known but not stageable due to coverage of wound bed by slough and/or eschar).</p> <p>A Care Plan, revised on 3/27/24, indicated pressure ulcers were present. The interventions</p> |   |  |   | <p>all wound treatments must be completed, per physician orders and documented on the TAR. DON/Designee also educated all Licensed Nurses and CNA's that if a wound vac comes off, the CNA must immediately notify the nurse and the nurse must apply the ordered rescue dressing.</p> <p>4 DON/Designee will conduct random observations 5x weekly, on residents who have ordered wound treatments, to ensure that the treatment is in place and that the dressing is current. Administrator/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.</p> |  |                            |

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| NAME OF PROVIDER OR SUPPLIER<br><br>GREAT LAKES HEALTHCARE CENTER |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2300 GREAT LAKES DR<br>DYER, IN 46311 |  |  |                            |
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|   | <p>included the treatments would be completed as ordered by the Physician.</p> <p>The current Physician's Orders indicated the following orders for the pressure wounds treatments:</p> <ul style="list-style-type: none"><li>- An order date of 3/2/24, indicated a wound vacuum was to be placed on the stage four pressure wounds on the sacrum and right ischium and was to be changed on Mondays, Thursdays and as needed on day shift.</li><li>- An order date of 3/6/24, indicated the left ischium pressure wound was to be cleansed with wound cleanser and a hydrocolloid dressing (enhances wound healing) was to be applied on Monday, Wednesday, Friday, and as needed, on the day shift.</li></ul> <p>The Wound Nurse Practitioner's Progress Note, dated 4/15/24, indicated:</p> <ul style="list-style-type: none"><li>- The sacrum pressure wound was a stage four and was improving without complications. The wound measured at 5 centimeters (cm) in length by 6.3 cm in width and 1.5 cm in depth. The wound had undermining from 9 o'clock to 3 o'clock with a depth of 2.8 cm. 75-99% of the wound had granulation tissue and 1-24% slough. There was moderate amount of serosanguinous drainage.</li><li>- The right ischium pressure wound was a stage four and was improving without complications. The wound measured 5.3 cm in length by 4 cm in width and 0.7 cm in depth. There was 75-99% granulation tissue and 1-24% slough. There was a moderate amount of serosanguinous drainage.</li><li>- The left ischium area was identified as moisture associated skin damage (MASD) and partial thickness of the skin was present. The area was</li></ul> |   |  |  |  |  |                            |

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| F 0880<br>SS=E<br>Bldg. 00  | <p>improving without complications and was 100% epithelial tissue. There was a scant amount of serosanguinous drainage.</p> <p>During an interview on 4/23/24 at 11:24 a.m., the Director of Nursing indicated she had interviewed the CNA who worked the night shift on 4/21/24 - 4/22/24 and was informed the resident's dressings had come off during the night and she had forgotten to let the nurse know.</p> <p>An undated, "Skin Care &amp; Wound Management" policy, received from the Administrator as current on 4/23/24 at 10:53 a.m., indicated skin care and wound management would include application of treatments and daily monitoring of the existing wounds.</p> <p>This citation relates to Complaints IN00429320 and IN00429834.</p> <p>3.1-40(a)(2)</p> <p>483.80(a)(1)(2)(4)(e)(f)<br/>Infection Prevention &amp; Control<br/>§483.80 Infection Control<br/>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.</p> <p>§483.80(a) Infection prevention and control program.<br/>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> |   |  |   |  |  |                            |

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|   | <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> |   |  |   |  |  |                            |

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|   | <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.<br/>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.<br/>The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, related to improper PPE (personal protective equipment) prior to providing care to a resident on enhanced barrier precautions (EBP) and hand hygiene not completed after direct resident care, for 2 of 5 residents observed for infection control practices. (Residents C and G) This had the potential to affect the residents on 2 of 3 Units (East and West) and residents who required treatment for pressure wounds.</p> <p>Findings include:</p> <p>1. Prior to entering Resident C's room on 4/22/24 at 8:27 a.m., there was no sign on the door that indicated enhanced barrier precautions were to be used. There was a container of PPE located on the wall inside the door.</p> <p>During an observation on 4/22/24 at 8:27 a.m., Resident C was lying in bed. The resident had urinary catheter. CNA 2 donned gloves and</p> |   |  | F 0880  | <p>1 Resident C and Resident G were assessed and had no adverse effects related to the alleged deficient practice.</p> <p>2 All residents with enhanced barrier precautions were reviewed to ensure appropriate systems were in place to meet the guideline.</p> <p>3 DON/Designee has educated all facility staff on the handwashing policy and the enhanced barrier precaution policy.</p> <p>4 DON/Designee will conduct infection control rounds 5 x weekly, with the focus being on ensuring the facility staff is adhering to the handwashing and enhanced barrier precaution policies. Administrator/Designee</p> |  | 05/10/2024                 |

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|   | <p>unstuck the tabs on the incontinent brief. He was then stopped prior to any other care completed and asked if he should have any other special PPE on for care. CNA 2 indicated he did not need anything other than gloves on. He indicated he had not received education on enhanced barrier precautions. He then removed the gloves and left the room to go get help. No hand washing was completed upon leaving the room.</p> <p>CNA 2 and CNA 7 returned to the room. Hand hygiene was performed and gloves and a gown were donned from the supply located inside the door of the room. The resident's incontinent brief was undone and the resident was rolled onto her left side. The pressure area on the sacrum/coccyx area had foam inside of the area and the wound vacuum was not in place. There was no dressing covering the area. The pressure area on the left ischium had no dressing covering it, and there was no dressing on the right ischium pressure ulcer.</p> <p>The sheets were changed and the soiled items were placed in a plastic bag. CNA 7 completed hand hygiene after removal of the PPE. CNA 2 removed the gloves and gowns and left the room with the soiled bag without hand hygiene and walked down the hall to the Soiled Utility Room.</p> <p>During an observation on 4/22/24 at 1:02 p.m., the Wound Nurse Practitioner and Wound Nurse 1 entered the room for wound care treatment to be completed. Both had donned gloves and had brought supplies in for the treatment and were beginning to start the treatment when stopped prior to care started and were asked about EBP. Gowns were then donned. Wound Nurse 1 indicated she usually dons the PPE, but she was tired and forgot.</p> |   |  |   | <p>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 achieve Date of completion:</p> |  |                            |

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|   | <p>Resident C's record was reviewed on 4/22/24 at 1:17 p.m. The diagnoses included, but were not limited to, multiple sclerosis.</p> <p>An Admission Minimum Data Set assessment, dated 2/21/24, indicated a moderately impaired cognitive status, no behaviors, impairment of the bilateral upper and lower extremities. She required maximum assistance with toileting and bed mobility, was dependent for transfers and showers, and had an indwelling urinary catheter and was frequently incontinent of bowel movement. She was admitted into the facility with two stage four pressure ulcers (full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) and two unstageable pressure ulcers (pressure ulcer known but not stageable due to coverage of wound bed by slough and/or eschar).</p> <p>A Care Plan, dated 2/23/24, indicated an indwelling urinary catheter was present. The interventions included enhanced barrier precautions with dressing/bathing/showering/transferring/personal hygiene/changing linens/toileting/peri-care, and providing care to the urinary catheter would be used.</p> <p>A Care Plan, dated 2/23/24, indicated a history of vancomycin-resistant enterococcus (VRE) wound and urine infections. The interventions included enhanced barrier precautions with dressing/bathing/showering/transferring/personal hygiene/changing linens/toileting/peri-care, and providing care to the urinary catheter would be used.</p> |   |  |   |  |  |                            |

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|   | <p>A Physician's Order, dated 2/22/24, indicated enhanced barrier precautions were to be used, related to an indwelling catheter and a history of or colonized multi-drug resistant organism.</p> <p>2. During an observation on 4/22/24 at 10:22 a.m., Resident G was lying in bed with the head of the bed up. CNA 3 and CNA 4 entered the room. They pulled the resident up in bed by using the sheet underneath the resident. Neither CNA had donned gloves. CNA 3 then exited the room without hand hygiene and walked down the hall and retrieved a blanket from the linen closet and covered the resident with the blanket. CNA 3 then exited the room with the soiled blanket taken off the resident in his hands without placing the blanket in a plastic bag and without hand hygiene. CNA 4 completed hand hygiene upon leaving the room, using the alcohol based hand rub located outside the resident's door.</p> <p>During an interview on 4/22/4 at 1:30 p.m., the Director of Nursing indicated the facility educated the staff in the past week and there should be sign for the EBP and the PPE's on the resident's door.</p> <p>An educational training sign in form, dated 4/18/24, indicated an inservice on EBP, hand hygiene and glove usage was given to 21 nursing employees. CNA 2, CNA 3, and Wound Nurse 1 had not attended the education.</p> <p>3.1-18(b)</p> |   |  |   |  |  |                            |