STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Lakes Healthcare Center	2300 Great Lakes Dr Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 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. (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 [DATE] 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 outer thigh. There was no documentation the resident's POA was notified of the fluid filled blister. (continued on next page)

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 90 days 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 14 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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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: - [NAME] Blood Cells were 13.08 a high value (normal range 4.8-10.8) - 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 [NAME] 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. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-5(a)(2) 3.1-5(a)(3) 3.1-5(a)(4)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 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 [DATE]. 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. 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 performed for falls with unknown head injury. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation relates to Complaint IN00436341. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 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 [DATE]. 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. 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., 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)