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	02/05/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on record review and interview, the facility failed to identify a resident with continued significant weight loss and provide interventions/care planning for the weight loss for 1 of 3 residents reviewed for nutrition and weight loss. (Resident D)Finding Includes:Resident D's record was reviewed on 2/5/26 at 11:41 a.m. The diagnoses included, but were not limited to, Parkinson's disease, diabetes mellitus, and morbid obesity.A Significant Change Minimum Data Set assessment, dated 12/14/25, indicated a moderately impaired cognitive status, no behaviors, was able to feed herself after set up, was dependent for toileting, bathing, and transfers, and required maximum assistance with hygiene and bed mobility. The weight was 294 pounds and had no known significant weight loss or gain. She received a therapeutic diet and a hypoglycemic.A Care Plan, revised on 12/23/25, indicated there was a nutritional problem. The reasons for the nutritional problem included, but not limited to, an increased body mass index (BMI) over 40, received a therapeutic diet, and had a weight gain. The goal indicated the resident would maintain adequate nutritional status and a stable weight. The interventions included, the meal intakes would be monitored, A nutritional consult would be completed on admission, quarterly, and as needed, a weekly weight would be obtained if there was an unplanned weight loss identified, and meals would be provided per the Physician's Orders.The resident's weights were as follows:On 7/2/25 - 296.6 pounds.On 7/30/25 - 305.2 pounds.On 8/4/25 - 303.4 pounds.On 9/2/25 - 303.2 pounds.On 10/7/25 - 286.4 pounds.On 11/5/25 - 293.5 pounds.A Nurse's Progress Note, dated 11/29/2025 9:31 p.m., indicated the resident had been transferred and admitted to the hospital due to shortness of breath.A Nurse's Progress Note, dated 12/3/2025 at 3:38 p.m., indicated the resident had returned and was readmitted into the facility. A Physician's Order, dated 12/6/25, indicated a weekly weight was to obtained for four weeks.The Medication Administration Record (MAR), dated 12/2025, indicated a weight was obtained on 12/12/25 and was 293.5 pounds. There were no other weekly weights documented on the MAR or in the record until 2/3/26. A Registered Dietician's (RD) Dietary and Nutritional Assessment, dated 12/15/25, indicated a weight of 293.5 in November 2025. The resident received a Carbohydrate Controlled Diet. The dietary intakes were 75-100%. The average calorie intake was 1595-2129 calories. The BMI was 46 and the usual body weight was 290-300 pounds. The resident reported she wanted to lose weight. The estimated calorie needs were 1850-2200. The RD would continue to monitor weights, lab tests and meal time acceptance. The goals included, to tolerate the diet as ordered, maintain an adequate nutritional status, the weight would be maintained without a significant change, and the resident would receive the diet as ordered.There were no interventions or care plan for the resident's request to lose weight. There was no documentation the staff, physician or responsible party were notified. An A1c (blood glucose levels over the past 2-3 months), completed on 1/8/26, was 8.1 (normal 4.8-5.6). A 1/8/26 Comprehensive Metabolic Profile (CMP) lab test indicated a blood urea nitrogen(BUN) (measures kidney function) of 32 (normal 9-23), creatinine level (kidney function) of 2.04 (normal 0.55 - 1.02), and a glomerular filtration rate (GFR) (measures filtration of kidney) was 26.08 (Normal >60).A (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

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	02/05/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Practitioner's (NP) Progress Note, dated 1/16/26, indicated the visit was on 1/15/26 and the visit was for lab test follow up. The resident had elevated A1C (blood sugars over time) and elevated creatinine (kidney function) levels. The medications of Lisinopril (anti-hypertensive) and Metformin (hypoglycemic) was discontinued and Moujaro (a GLP-1) was to be initiated. The resident's weight was 293.5 pounds on 12/12/25. The plan included: elevated creatinine and decreased GFR (glomerular filtration rate - kidney function test). The Lisinopril and Metformin were discontinued and Monjaro was to be started. A Physician's Order, dated 1/19/26, indicated Moujaro 2.5 milligrams per 0.5 milliliters was to be administered every Monday until 2/16/26.A weight, dated 2/3/36, was 259.3 pounds. This was a 11.6 % loss from 12/12/25 and a 14.5% loss in six months. The dietary intake records, dated 12/2025, 1/2026, and 2/2026, indicated the average intake of meals was 76-100%.An RD's Progress Note, dated 2/5/26 at 1:53 p.m., indicated a weight of 259.3 which was a loss of 10% in 180 days. A weight discrepancy was noted and would be requesting a re-weight to determine weight accuracy. During an interview on 2/5/26 at 2:18 p.m., the Corporate RN Consultant indicated a weight was obtained 12/8/25 and was 272.1 pounds (weight loss of 7.29% in on month). The weight had not been documented in the record, so staff were not monitoring and the RD was not aware. The weight on 12/12/25 was incorrect. The weekly weights had not been completed. She indicated another weight had been obtained on 1/5/26 at 264.6 pounds (additional 2.76 % loss in one month and a 13.3% loss in six months). The weight on 1/5/26 had also not been documented in the record so no one was aware there was a weight loss. The Physician, NP, RD and Responsible Party had not been made aware of the weight loss. The Restorative Aide, who identified herself as the staff member obtaining the weights, indicated she weighs the residents, writes the weight on a paper, and turns it into the Unit Manager who was to document the weights in the record. She indicated she does not have access to the past weights and was unaware the resident was to be weighed weekly. The Corporate RN Consultant indicated the Unit Manager at that time was no longer employed at the facility and today's re-weight was 259.9 pounds.During the Exit Conference on 2/5/26 at 3:50 p.m., the Corporate RN Consultant indicated in January the facility identified inconsistent weight fluctuations and a performance plan was initiated on 1/29/26. She indicated the lack of documentation of weights and the weight loss for Resident D had not been identified prior to the 2/5/26 survey investigation.An undated weight policy, received as current from the Corporate RN Consultant on 2/5/26 at 3:17 p.m., indicated weights would be obtained monthly or as ordered by the physician or practitioner. The weight, scale used, and any unusual events associated with obtaining the weight was to be documented in the resident's record. The resident was to be weighed upon 24 hours of admission and weekly weights for four weeks were to be obtained after the admission and documented in the resident's record. Weight loss concerns were to be reported to the practitioner and discussed at the weekly clinical meetings.This citation relates to Intakes 2719710 and 2727921.3.1-46