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	06/17/2026

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

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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. Based on observation, record review, and interview, the facility failed to ensure skin rashes were treated for 1 of 3 residents reviewed for non-pressure related skin conditions and medications were administered as ordered by the physician for 1 of 3 residents reviewed for pain. (Residents S and F)Findings include: 1. During a random observation on 6/16/26 at 2:43 p.m., Resident S was observed in bed. CNA 1 and CNA 2 entered the room to provide incontinence care. Both CNAs unfastened the incontinence brief and removed it. CNA 1 wiped the resident's peri area, as there was bowel movement observed. They rolled the resident onto to her right side, and there was a large bandage covering her sacral area that was dated 6/15/26. The skin surrounding the bandage was clean and pink. CNA 2 provided incontinence care to remove the rest of the bowel movement. CNA 2 removed the cap from a tube of Calmoseptine ointment (a moisture barrier ointment) and spread it on her buttocks below the bandage. The record for Resident S was reviewed on 6/16/26 at 1:31 p.m. Diagnoses included, but were not limited to, peg tube (a tube inserted directly into the stomach for nutrition), heart failure, and obstructive and reflux uropathy (a blockage in the urinary tract). The 4/22/26 Significant Change Minimum Data Set (MDS) assessment indicated the resident was severely impaired for decision making. A Care Plan, dated 1/27/26, indicated the resident was at risk for pressure ulcer development, impaired skin integrity, or at risk for altered skin integrity related to a decline in functional status. The approaches were to administer treatments as ordered by the medical provider. A Wound Nurse Practitioner (NP) Note, dated 5/11/26, indicated the resident had a new onset of irritant contact dermatitis on the inner buttocks. The wound base was 100% epithelial tissue (body tissue) and the edges were attached. The treatment recommendation was to cleanse the area with wound cleanser, apply Zinc Oxide Paste (a skin protectant) to the base of the wound, and leave open to air daily and as needed (PRN). There was no physician's order written or implemented for the wound cleanser treatment or Zinc Oxide paste to the inner buttocks. A Wound NP Note, dated 5/21/26, indicated to continue zinc oxide-based barrier cream to the contact dermatitis. A Physician's Order, dated 5/21/26, indicated Zinc Oxide External Ointment 20%, apply to affected area topically as needed (PRN) for dry skin. There was no daily scheduled Zinc Oxide administration order written and no wound cleanser (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment. The Wound NP Notes, dated 6/8/26 and 6/15/26, indicated the contact dermatitis remained with 100% epithelial tissue and the treatment remained the same. The dermatitis to the buttocks was improving. The Medication and Treatment Administration Records (MAR/TAR) for the months of 5/2026, and 6/2026 indicated the Zinc Oxide ointment was not signed out as being administered. During an interview on 6/16/26 at 3:45 p.m., the Wound Nurse indicated the dermatitis was right under the wound on the inner buttocks. She was unaware there was a treatment order for the dermatitis from the Wound NP for the Zinc Oxide. She had no additional information to provide. 2. During an interview on 6/15/26 at 1:45 p.m., Resident F indicated staff was not giving her the correct medications. When she questioned the staff, they would tell her she was wrong. She indicated on 6/14/26, the nurse tried to give her eight pills in the morning, but she was supposed to have seven. The nurse told her she was getting two Lasix (a diuretic, used to treat fluid retention) but she knew that was not right. The record for Resident F was reviewed on 6/15/26 at 9:46 a.m. Diagnoses included, but were not limited to, aftercare following joint replacement surgery, infection due to joint prosthesis, and diabetes. The Medicare-5 Day Minimum Data Set (MDS) assessment, dated 4/22/26, indicated the resident was cognitively intact for daily decision making and was dependent for activities of daily living (ADLs). A Physician's Order, dated 6/12/26, indicated Lasix 20 mg (milligrams), one tablet by mouth, one time a day. An Alert Charting Note, dated 6/14/26 at 6:51 p.m., indicated . Reason for assessment: Other. Description of other reason for assessment: Med [medication] error. Description of event or change: The patient reported receiving a medication cup from the day shift nurse that contained a large number of pills. When the patient requested clarification about the medications, the nurse did not provide additional information. Additionally, the patient observed that her scheduled evening medication was absent from the medication administration strip following the shift change. The situation was reported promptly to address the error and ensure patient safety.Interventions in use: Vital signs monitored Neuro checks initiatedNotifications Made: Provider notified Resident/Resident Representative notifiedResident is currently stable.New orders for the resident have not been received.Follow-up plan: n/aResident remains in the facility.Resident was seen by the Physician during the shift.Summary of outcome: n/a. During an interview on 6/17/26 at 12:30 p.m., the Regional Director of Clinical Operations indicated on 6/14/26, RN 1 dispensed two Lasix pills with the intent to administer to the resident, but she should only have given her one. The facility was investigating the medication error and RN 1 was suspended. This citation relates to Intakes 3012287 and 3018321. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review, and interview, the facility failed to ensure the head of the bed was elevated to at least a 30 degree angle for a resident with an enteral feeding (tube feeding) that was infusing for 1 of 1 resident randomly observed for tube feeding. (Resident S) Finding includes:During a random observation on 6/16/26 at 2:43 p.m., Resident S was observed in bed with a tube feeding infusing at 65 cubic centimeters (cc) per hour on a pump. CNA 1 and CNA 2 entered the room to provide incontinence care. CNA 2 took the remote control for the bed and laid the resident's head of the bed all the way down so she was completely flat in the bed. CNA 1 was asked if she had put the tube feeding on hold and she indicated she did not. CNA 2 was then instructed to raise the head of the bed immediately.During an interview at that time, CNA 2 was unaware the head of the bed was not supposed to be flat while the enteral feeding was infusing.The record for Resident S was reviewed on 6/16/26 at 1:31 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), peg tube (a tube inserted directly into the stomach for nutrition), heart failure, and chronic respiratory failure with hypoxia.The 4/22/26 Significant Change Minimum Data Set (MDS) assessment indicated the resident was severely impaired for decision making, had a peg tube, and received an enteral feeding. A Care Plan, dated 4/24/26, indicated the resident required a tube feeding. The approaches were to ensure the head of the bed was elevated to 30 degrees. A Physician's Order, dated 6/5/26, indicated Jevity 1.5 at 65 milliliters (ml) per hour for 20 hours via pump, on at 7:00 a.m. During an interview on 6/16/26 at 3:15 p.m., the Regional Director of Clinical Operations indicated the CNA should not have put the head of the bed down while the enteral feeding was infusing. CNA 2's Nurse Aide Orientation/Training Guide, dated 6/3/26, indicated the CNA was signed off as having demonstration and return demonstration of resident environment and safety of turning and repositioning with tubing. During an interview on 6/17/26 at 12:07 p.m., CNA 3 indicated she had trained CNA 2 during orientation. She had shown the CNA how to position tubing whether it was Foley or a peg tube so that it did not get pulled out during transfers. She also instructed the CNA not to ever lay the head of the bed down while the tube feeding was infusing. The current Enteral General Nutritional (tube feeding) Guidelines policy, provided by the Administrator on 6/17/26 at 11:47 a.m., indicated residents that received bolus and/or intermittent feeding would have the head of the bed elevated at least 30 degrees during feeding and 1 (one) hour post feedings to decrease the risk for respiratory aspiration. Residents receiving continuous meals would maintain the head of the bed at least 30 degrees to reduce aspiration.410 IAC (Indiana Administrative Code) 16.2-3.1-44(a)(2)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, record review, and interview, the facility failed to ensure intravenous (IV) access sites were assessed and flushed regularly for 2 of 3 residents reviewed for IV therapy. (Residents J and H) Findings include:1. During an observation on 6/16/26 at 8:07 a.m., Resident J was resting in bed. She had an implanted port on her right upper chest, and an infusion was in progress via a pump. The record for Resident J was reviewed on 6/15/26 at 3:58 p.m. Diagnoses included, but were not limited to, diabetes, endometrial cancer, and nephrostomy (a tube inserted to drain the kidney).The Quarterly Minimum Data Set (MDS) assessment, dated 6/5/26, indicated the resident was cognitively intact for daily decision making, and required substantial assistance with activities of daily living (ADLs).A Care Plan, initiated on 4/4/25, indicated the resident had a right chest port. Interventions included to flush the site every 24 hours and visually inspect it each shift. A Physician's Order, dated 6/11/26, indicated Cipro (an antibiotic) IV (intravenously) twice a day, until 6/17/26. Start on 6/11/26 at 8:00 a.m.The Medication Administration Record (MAR) for June 2026 indicated the resident received the IV antibiotic twice a day from 6/11/26 through 6/16/26.The record lacked documentation of an assessment and flushing of the IV site (right chest port). During an interview on 6/16/26 at 10:05 a.m., the Regional Director of Clinical Operations and the Divisional Director of Clinical Services indicated the flushing and site assessment should be documented every shift. 2. During an observation on 6/16/26 at 8:45 a.m., Resident H was observed resting in bed. A PICC line (a temporary IV access) was observed in his right arm. At that time, there was no infusion in progress. The resident's record was reviewed on 6/16/26 at 9:42 a.m. Diagnoses included, but were not limited to, respiratory failure, diabetes, and pneumonia.The Medicare-5 Day Minimum Data Set (MDS) assessment, dated 5/13/26, indicated the resident was cognitively intact for daily decision making, and required substantial assistance with ADLs.A Care Plan, initiated on 3/23/26, indicated the resident had a PICC line in his right arm. Interventions included to flush the line and visually inspect the site each shift. Physician's Orders, dated 6/13/26, indicated Cresemba (an antifungal medication) IV daily and Zerbaxa (an antibiotic) IV three times a day for twenty days.The Medicaton Administration Record (MAR) for June 2026 indicated the resident received IV Cresemba on 6/13/26, 6/14/26, and 6/15/26 and the resident received IV Zerbaxa on 6/13/26 at 2:00 p.m. and 9:00 p.m., and 6/15/26 at 9:00 a.m., 2:00 p.m., and 9:00 p.m.The record lacked documentation of any assessment and flushing of the PICC site. During an interview on 6/16/26 at 10:05 a.m., the Regional Director of Clinical Operations and the Divisional Director of Clinical Services indicated the flushing and site assessment should be documented every shift.A policy titled, Intermittent Infusion, received from the Administrator as current on 6/16/26, indicated, . Flush venous access device with prescribed flushing agent . to maintain patency between intermittent infusions . Documentation in the medical record includes, but is not limited to . prescribed flushing agent(s) . site assessment .This citation relates to Intake 3018321.410 IAC (Indiana Administrative Code) 16.2-3.1-47(a)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure residents received medications as prescribed for 1 of 3 residents reviewed for pain and 1 of 3 residents reviewed for intravenous (IV) therapy. (Residents F and H) Findings include:1. During an interview on 6/15/26 at 1:45 p.m., Resident F indicated she was not getting her oxycodone (a narcotic pain reliever) every four hours as it was ordered. When she asked for it, the staff would say they did not have the medication or it was not available. The record for Resident F was reviewed on 6/15/26 at 9:46 a.m. Diagnoses included, but were not limited to, aftercare following joint replacement surgery, infection due to joint prosthesis, and diabetes.The Medicare-5 Day Minimum Data Set (MDS) assessment, dated 4/22/26, indicated the resident was cognitively intact for daily decision making, and was dependent in activities of daily living (ADLs). A Physician's Order, dated 4/29/26, indicated oxycodone 5 mg (milligrams) by mouth every four hours for pain.A Nurse's Note, dated 4/26/26 at 1:19 p.m., indicated the nurse contacted the pharmacy because the oxycodone was not available.A Nurse's Note, dated 4/29/26 at 5:03 p.m., indicated they were waiting for the pharmacy to deliver the oxycodone refill order. A Nurse's Note, dated 5/21/26 at 8:08 a.m., indicated an order was received to give the resident one dose of oxycodone 10 mg due to missing two prior doses. The Medication Administration Record (MAR) for May 2026 indicated the resident did not receive the scheduled doses of oxycodone on 5/21/26 at 2:00 a.m., 5/21/26 at 6:00 a.m., and 5/21/26 at 10:00 a.m.The MAR for June 2026 indicated the resident did not receive the scheduled doses of oxycodone on 6/6/26 at 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m.; on 6/7/26 at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m.; on 6/8/26 at 2:00 a.m., 6:00 a.m., and 10:00 a.m.During an interview on 6/17/26 at 12:30 p.m., the Divisional Director of Clinical Services indicated they were having trouble with the resident's prescription for the oxycodone. 2. The record for Resident H was reviewed on 6/16/26 at 9:42 a.m. Diagnoses included, but were not limited to, respiratory failure, diabetes, and pneumonia.The Medicare-5 Day Minimum Data Set (MDS) assessment, dated 5/13/26, indicated the resident was cognitively intact for daily decision making and required substantial assistance with ADLs. A Physician's Order, dated 6/13/26, indicated Zerbaxa (an intravenous antibiotic), three times a day for pneumonia. The Medication Administration Record (MAR) for June 2026 indicated the resident did not receive the scheduled doses of Zerbaxa on 6/14/26 at 9:00 a.m., 2:00 p.m., and 9:00 p.m. A Nurse's Note, dated 6/14/26, indicated they were waiting for the medication to arrive from the pharmacy. During an interview on 6/16/26 at 10:11 a.m., RN 2 indicated if they ordered a medication from the pharmacy, it would take up to 24 hours to receive it. The timeframe was the same for all types of medications, weekends and weekdays. An informational sheet from the pharmacy, received from the Administrator on 6/17/26 at 9:10 a.m., indicated the pharmacy was available 24 hours/day, 7 days/week. If a medication was not available and needed prior to the next delivery, staff should call the pharmacy for a STAT delivery. A Care Plan, revised on 6/12/26, indicated the resident had PICC line (a temporary intravenous access). Interventions included administering intravenous medications as ordered. During an interview on 6/17/26 at 1:00 p.m., the Regional Director of Clinical Operations was informed of the findings and had no additional information to provide. This citation relates to Intake 3018321.410 IAC (Indiana Administrative Code) 16.2-3.1-25(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review and interview, the facility failed to ensure infection control practices were in place and implemented related to staff failing to wear the correct personal protective equipment (PPE) for a resident in enhanced barrier precautions for 1 of 1 resident with a peg tube (a tube inserted directly into the stomach for nutrition) and an indwelling Foley (urinary) catheter. (Resident S) Finding includes:During a random observation on 6/16/26 at 2:43 p.m., Resident S was observed in bed with an enteral tube feeding infusing at 65 cubic centimeters (cc) per hour on a pump. The resident had an indwelling Foley catheter hanging on the side of the bed that was very full of urine. CNA 1 and CNA 2 entered the room to provide incontinence care. At that time, they both donned clean gloves to both hands without performing hand hygiene and neither one of them donned an isolation gown. Both CNAs unfastened the incontinent brief and removed it, and CNA 1 wiped the resident's peri area, as there was bowel movement observed. They rolled the resident onto to her right side and CNA 2 provided incontinence care to remove the rest of the bowel movement.During an interview at that time, both CNAs were asked if they were aware they were supposed to be wearing an isolation gown while performing care and coming in contact with the resident. CNA 1 indicated she was aware and CNA 2 did not answer the question. Neither CNA stopped what they were doing and donned an isolation gown. At 2:48 p.m., CNA 1 removed her gloves, threw them away, left the room, performed hand hygiene from the hand sanitizer dispenser in the hallway and walked down the hall. CNA 1 came back to the room at 2:50 p.m. and donned a pair of clean gloves to both hands without performing hand hygiene. She did not don an isolation gown. She walked back over to the bed and continued to assist CNA 1 with incontinence care.At 2:53 p.m., CNA 2 opened the drawer on the night stand and inside was a cylinder to empty the Foley catheter, he squatted down, opened the flange and poured the urine into the cylinder, he did not don an isolation gown.The record for Resident S was reviewed on 6/16/26 at 1:31 p.m. Diagnoses included, but were not limited to, peg tube (a tube inserted directly into the stomach for nutrition) and obstructive and reflux uropathy (blockage of urinary flow).The 4/22/26 Significant Change Minimum Data Set (MDS) assessment indicated the resident was severely impaired for decision making. The resident had an indwelling Foley catheter.A Care Plan, dated 4/27/26, indicated the resident required enhanced barrier precautions for the peg tube and Foley catheter. The approaches were to were to don the appropriate PPE (personal protective equipment) during high contact care by care givers (dressing, bathing/showering, transferring in room or therapy gym, providing hygiene, changing linens, changing briefs or assisting with toileting).A Physician's Order, dated 5/21/26, indicated enhanced barrier precautions related to a Foley & enteral feeding when dressing/bathing, showering/transferring in room or therapy gym/personal hygiene, changing linen, providing hygiene, changing briefs or assisting with toileting.During an interview on 6/16/26 at 3:15 p.m., the Regional Director of Clinical Operations indicated enhanced barrier precautions were to be implemented while providing care for the resident. The current Enhanced Barrier Precautions policy provided by the Administrator on 6/17/26 at 11:47 a.m., indicated Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employed hand hygiene, targeted gown and glove use during high contact resident care activities that include; Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care: any skin opening requiring adressing.This citation relates to Intake 3018321.410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)