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	12/21/2022

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 10770 Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders and an assessment to self-administer their own medications for 1 of 1 residents reviewed for self-administration of medication. (Resident S) Finding includes: On 12/13/22 10 a.m., and 2:54 p.m., Resident S was observed in bed. At those times, there was an inhaler observed of Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder 100-25 micrograms (mcg) on the over bed table. The resident indicated she used the inhaler 1 time every day. The record for the resident was reviewed on 12/15/22 at 11:25 a.m. Diagnoses included, but were not limited to, congestive heart failure, chronic respiratory failure, stroke, COPD, type 2 diabetes, sleep apnea, and bradycardia. The Annual Minimum Data Set (MDS) assessment, dated 10/12/22, indicated the resident was cognitively intact. There was no care plan to self-administer her medications. There was no self-administer of medications assessment completed for the resident. Physician's Orders, dated 9/22/22, indicated Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder Breath 100-25 mcg (Fluticasone Furoate-Vilanterol). Inhale 1 puff orally in the morning for COPD. Rinse and spit after every use. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated there was no self-administration of medication orders or an assessment for the resident. 3.1-11(a)

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on interview and record review, the facility failed to address resident council concerns in a timely manner for 1 of 1 resident council groups. This had the potential to affect all residents who attended or participated in the resident council group. Findings include: 1. The resident council minutes from the last 3 months were reviewed on 12/19/22 at 11:25 a.m. The 9/29/22 meeting minutes indicated there were no new concerns and they wanted their concerns from the August 2022 meeting addressed. The Old Business to be addressed were call lights, name tags, CNA rounds, food temperatures, and customer service concerns. The Administrator and the Director of Nursing were in attendance and informed the council there was no resolution for their concerns and they were following up. 2. During the resident council meeting held on 12/19/22 at 1:30 p.m., there were 8 residents who attended. The residents expressed a concern that they still had not received resolution for grievances filed from the 8/2022 meeting. In October, they were so angry they boycotted the meeting. The residents stated [Name] Administrator keeps saying he is new. [Name] the Director of Nursing says she is new and there is no staff, but they will keep working on it. The Activity Director completed all of the grievances and handed them to the department of concern. They were all aware of how to file personal grievance with the Social Service Director. A resident council grievance, dated 6/30/22, indicated the food was not hot enough when it was served. A summary of the interview indicated the dining room was now open and they were taking temps of the food three times a week. The resolution was blank and if the resident was satisfied was also blank. The grievance was signed by the Dietary Manager and the Administrator with no date. The resident council grievances, dated 8/25/22, indicated the following: a. Call light response: Residents indicated it takes a long time for someone to answer call lights on both units daily. The grievance was signed by Administrator with no date. There was no resolution or resident satisfaction completed. b. Residents don't know staff names or titles when approached by staff on both units. The grievance was signed by Administrator with no date. There was no resolution or resident satisfaction completed. c. CNA rounds: Residents indicated they were not being checked on every 2 hours on both units daily. The grievance was signed by Administrator with no date. There was no resolution or resident satisfaction completed. d. Residents indicated they were hearing CNA and other staff cussing and saying rude insults in the hallways on both units. The residents indicated there was poor customer service in the hallways and at the nurses' station on both units. The grievance was signed by Administrator with no date. There was no resolution or resident satisfaction completed. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Residents indicated the food was cold when they received it in their rooms for all meals on both units. The grievance was signed by Administrator with no date. There was no resolution or resident satisfaction completed. Interview with the Administrator on 12/20/22 at 9:00 a.m., indicated he was aware the grievances for the council were still a work in progress and documentation was lacking of the resolutions. The information was not being passed onto the residents. Interview with the Activity Director on 12/20/22 at 9:22 a.m., indicated during the council meetings she completed the grievance forms based on the residents' concerns and turned them into the Administrator if they were building concerns and the Director of Nursing if they were nursing concerns. At the meeting in 9/2022, the council wanted all of their past grievances from 8/2022 acted on. They boycotted the meeting for 10/2022 and just had one at the and of 11/2022. She expected the department heads to give their resolution to her by the next meeting within 30 days. The current 6/19/18, Resident Grievance policy, provided by the Nurse Consultant on 12/20/22 at 9:30 a.m., indicated upon receipt of an oral, written, or anonymous grievance submitted by a resident the Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation was being investigated, if indicated. The grievance review will be completed in a reasonable time frame consistent with the type of grievance but not exceed 30 days. The Grievance Official will meet with the resident and inform the resident of the results of the investigation and how the resident's grievance was resolved or will be resolved. A copy of the grievance decision will be provided to the resident upon request. This Federal tag relates to Complaint IN00388811. 3.1-3(l)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 10770 Based on record review, and interview, the facility failed to investigate and resolve resident grievances that were reported to staff for 4 of 4 residents reviewed for grievances. (Residents C, K, E, and H) Findings include: 1. During an interview with Resident C on 12/13/22 at 2:04 p.m., indicated she had filed many grievances in the last couple of months about missing her medications, the food, and staffing and there was no follow up or resolution. During an interview on 12/20/22 at 3:00 p.m., Resident C expressed how offended she was and humiliated in front of other residents when another resident cursed at her and told her to shut up and mind her own business. The resident indicated it happened in November of this year and she filed a grievance against the resident for being so rude. No one had ever spoken to her about the incident or even looked into the matter. The record for Resident C was reviewed on 12/20/22 at 12:15 p.m. Diagnoses included, but were not limited to, heart failure, renal dialysis, type 2 diabetes, high blood pressure and heart disease. The Quarterly Minimum Data Set (MDS) assessment, dated 11/15/22, indicated the resident was cognitively intact. A grievance, dated 8/24/22 at 11:20 p.m., indicated the resident reported not receiving her 8 p.m. medications through a text message to the Social Service Director (SSD) at 11:20 p.m. The SSD notified the Director of Nursing (DON). The resolution indicated the nurse was notified and ordered to give the meds. The medications were given and the nurse was disciplined. The resident notification of resolution/satisfaction was blank. The grievance was signed by the Assistant Director of Nursing and Administrator on 8/24/22. A grievance, dated 11/12/22 at 11:00 a.m., recorded by the Activity Director, indicated during an activity, a male resident (name) was playing dice with other residents. The resident was sitting next to Resident C and she asked what he rolled on the dice. The male resident said mind your own f****** business. Resident C said, you know I cannot see. He said, we all know you cannot see. Resident C stated do you have to say the F word? The male resident stated, last time I checked this is a free country. Resident C did not respond to him. The location of the incident was in the main dining room in front of 7 other residents. The entire investigation, resolution, and interviews were blank and not completed. The Administrator had signed the grievance with no date noted. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated there was no follow up for the resident's grievances. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Interview with Resident K on 12/14/22 at 10:00 a.m., indicated the food was terrible and meals were always late. The resident had missed meals before and she filed a grievance regarding the issue. She had also filed grievances for the food being cold and missing medications, however, no one ever gets back to her with the resolution. The record for Resident K was reviewed on 12/16/22 at 11:15 a.m. Diagnoses included, but were not limited to, bipolar disorder, vascular dementia, delusional disorder, high blood pressure, and schizoaffective disorder. The 12/2/22 Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. A grievance, dated 8/24/22, indicated the resident reported not receiving evening medications on the west unit. The resolution indicated the nurse was notified and ordered to give the meds. The medication were given and the nurse was disciplined. The resident notification of resolution/satisfaction was blank. The grievance was signed by the Assistant Director of Nursing and Administrator on 8/24/22. A grievance, dated 8/29/22, indicated there was no cold cereal on her tray and she did not get eating utensils. The resolution was will inservice staff to check trays. The resident notification of resolution/satisfaction was blank. The grievance was signed by the Registered Dietitian and Administrator on 8/30/22. A grievance, dated 10/11/22 at 6:15 p.m., indicated the resident was served dinner at 6:15 p.m. and received a chicken salad sandwich. The resident had concerns regarding the sandwich as she was once hospitalized in February of 2022 and requested something else and informed the CNA. The CNA came back to the resident's room and informed her the kitchen was closed and there was no food available or people to prepare anything for the resident. The resident documented that she reported the incident to the nurse on duty who went to the kitchen and was also informed the same thing, there was no food available. The CNA did come back later and brought a peanut butter and jelly sandwich for the resident, however, she had already ordered out for dinner because she was hungry. There were 3 pages of hand written concerns attached to the grievance form. The grievance was not investigated, resolved or signed by any facility staff. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the grievances were not resolved. 3. During an interview with Resident E on 12/13/22 11:00 a.m., indicated the food was terrible and she does not know what was on the menus. The record for Resident E was reviewed on 12/15/22 at 10:00 a.m. Diagnoses included, but were not limited to, COPD, bipolar disorder, anxiety, major depressive disorder, unspecified dementia with behavioral disturbances, schizophrenia, and dependence on oxygen. The Quarterly Minimum Data Set (MDS) assessment, dated 10/14/22, indicated the resident was cognitively intact. She was totally dependent on staff with 1 person physical assist for bathing. In the last 7 days the resident received an antipsychotic medication 7 times, anti-anxiety medication 7 times, and antidepressant medication 7 times. The resident did not use oxygen. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A grievance, dated 9/21/22, indicated the resident did not know what was on the menu for breakfast, lunch and dinner. The summary of the interview indicated menus were being placed on units and will being doing updates. The resident notification of resolution/satisfaction was blank. The Dietary Manager and Administrator signed the grievance on 9/22/22. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the grievance was not resolved or follow up completed. 4. Interview with Resident H on 12/13/22 at 10:25 a.m., indicated the resident ate all of his meals in his room. The food was cold all of the time. The food sucks and they did not follow his food likes and dislikes. The record for Resident H was reviewed on 12/16/22 at 10:00 a.m. Diagnoses included, but were not limited, depressive disorder, osteoarthritis, high blood pressure, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 12/3/22, indicated the resident was cognitively intact. He was an extensive assist with 2 person physical assist for bathing and extensive assist with 1 person physical assist for personal hygiene. The resident's vision was adequate. A grievance, filed on 8/2/22, indicated the resident reported the food was always cold on the west unit. The summary of the interview indicated the food was getting better, and the resident would like double portions. The resolution was not completed and the resident notification of resolution/satisfaction was blank. The grievance was signed by the Dietary Manager and the Administrator on 8/3/22. A grievance, filed on 11/2/22, indicated the food was poor quality and the portions were small. The food does not match the meal ticket and there was no hot plate. The summary of the interview indicated the resident stated the roast beef is like chewing on the end of a belt. The resolution was to inservice staff on hot plates and checking meal tickets. The resident notification of resolution/satisfaction was not completed. The grievance was signed by the Administrator, Dietary Manager and the Registered Dietitian on 11/14/22. A grievance, dated 11/7/22, indicated the food was cold and he was not getting what was on the meal ticket. The summary of the interview indicated staff were inserviced on using hot plates and checking meal tickets. The resolution was not completed and the resident notification of resolution/satisfaction was blank. The grievance was signed by the Dietary Manager and the Administrator on 11/8/22. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the grievances were not resolved. The current 6/19/18, Resident Grievance policy, provided by the Nurse Consultant on 12/20/22 at 9:30 a.m., indicated upon receipt of an oral, written, or anonymous grievance submitted by a resident the Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation was being investigated, if indicated. The grievance review will be completed in a reasonable time frame consistent with the type of grievance but not exceed 30 days. The Grievance Official will meet with the resident and inform the resident of the results of the investigation and how the resident's grievance was resolved or will be resolved. A copy of the grievance decision will be provided to the resident upon request. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This Federal tag relates to Complaints IN00387079 and IN00388811. 3.1-7(a)(2)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on record review and interview, the facility failed to ensure residents or Responsible parties were invited to attend and participate in care planning conferences and care plans were updated to reflect the resident for 4 of 27 residents whose care plans were reviewed. (Residents 5, H, M, and F) Findings include: 1. Interview with Resident 5's Mother on 12/14/22 at 9:56 a.m., indicated she used to be invited to the resident's care conference but not recently. The record for Resident 5 was reviewed on 12/19/22 at 9:48 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), urinary tract infection, and schizoaffective disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/17/22, indicated the resident had short and long term memory problems and she was severely impaired for daily decision making. The Care Plan conference summary, dated 12/30/21 at 4:05 p.m., indicated a Care Plan meeting was held with the Interdisciplinary Team (IDT) and the resident's Mother was updated via a phone call. The resident's Care Plan was reviewed on 1/30, 3/17, 6/17, 9/17, and 12/17/22. There was no documentation the resident's Mother had been invited and/or attended the care conference. Interview with the Director of Nursing on 12/19/22 at 4:00 p.m., indicated the resident's Mother should have been invited to the Care Plan meetings. 10770 2. During an interview on 12/13/22 at 10:24 a.m., Resident H indicated he has had no recent care conference. The record for Resident H was reviewed on 12/16/22 at 10:00 a.m. Diagnoses included, but were not limited, depressive disorder, osteoarthritis, high blood pressure, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 12/3/22, indicated the resident was cognitively intact. A care conference was held with the resident and daughter on 7/14/22. There were no other care conferences completed for the resident. Interview with the Director of Nursing (DON) on 12/20/22 at 4:00 p.m., indicated the old Social Service Director left in November and his care conference was missed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The record for Resident M was reviewed on 12/19/22 at 10:15 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included but were not limited to, respiratory failure, tracheostomy, psychotic disorder, schizoaffective disorder, sleep apnea, high blood pressure, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 10/4/22, indicated the resident was cognitively intact. In the last 7 days the resident had received an antipsychotic medication 7 times. A Care Plan, revised on 4/8/22, indicated the resident received an antipsychotic medication related to depression and sleeplessness. Physician's Orders, dated 7/19/22, indicated Quetiapine Fumarate (an antipsychotic medication) tablet 25 milligrams (mg) daily. The medication was discontinued on 10/25/22. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the Care Plan was outdated. 45666 4. During an interview with Resident F on 12/14/22 at 9:57 a.m., the resident indicated he was never involved in a care plan meeting. Resident F's record was reviewed on 12/16/22 at 12:08 p.m. Diagnoses included, but were not limited to, syncope and collapse, heart failure, stroke, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 11/26/22, indicated the resident was moderately cognitively impaired. The last documented care conference was 6/16/22. Interview with the Director of Nursing on 12/19/22 at 3:43 p.m., indicated she had no further information to provide. 3.1-35(d)(2)(B)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review and interview, the facility failed to provide ADL (activities of daily living) assistance to dependant residents related to completing scheduled showers, nail care, hair washed, and shaving male residents for 6 of 10 residents reviewed for ADL care. (Residents N, E, H, M, P, and O) Findings include: 1. On 12/14/22 at 9:30 a.m., Resident N was observed in bed with his eyes open. The resident was unshaven and his fingernails were long and dirty. On 12/15/22 at 9:40 a.m., 11:30 a.m., and 1:08 p.m., the resident was observed in bed. At those times, the resident was unshaven and his fingernails were long and dirty. On 12/16/22 at 5:30 a.m., and 10:00 a.m., the resident was observed in bed. At those times, the resident was unshaven and his fingernails were long and dirty. The record for the resident was reviewed on 12/16/22 at 6:50 a.m. Diagnoses included, but were not limited to, stroke, type 2 diabetes, chronic kidney disease, heart failure, depressive disorder, atrial fibrillation, altered mental status, and high blood pressure. The Quarterly 10/23/22 Minimum Data Set (MDS) assessment indicated the resident was not alert and oriented and was severely impaired for decision making. The resident was an extensive assist with a 1 person assist for personal hygiene and totally dependent on staff for bathing. The Care Plan, revised on 4/6/22, indicated the resident had an ADL self care deficit and required assistance. The shower sheets indicated the resident received a bed bath on 12/7, however, being shaved was not checked as being done. The resident refused a shower on 12/10/22. A shower was given on 12/14/22 and shaved was not checked as being completed. No shower or bath was completed on 12/3 and 12/17/22. Interview with the Nurse consultant on 12/20/22 at 3:18 p.m., indicated the resident should have been shaved and his nails trimmed and cleaned. 2. During an interview with Resident E on 12/13/22 11:00 a.m., she indicated she did not get 2 bed baths twice a week and only gets her hair washed when a certain CNA was there. She had not had her hair washed in weeks. The record for Resident E was reviewed on 12/15/22 at 10:00 a.m. Diagnoses included, but were not limited to, COPD, bipolar disorder, anxiety, major depressive disorder, unspecified dementia with behavioral disturbances, schizophrenia, and dependence on oxygen. The Quarterly Minimum Data Set (MDS) assessment, dated 10/14/22, indicated the resident was cognitively intact. She was totally dependent on staff with 1 person physical assist for bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Care Plan, revised on 2/1/22, indicated the resident had an ADL deficit related to weakness and incontinence. The resident was to receive bed baths on Tuesdays and Fridays. There was no documentation the resident received a bath on 11/22, 11/25, and 12/1/22. There was no documentation on the shower sheets if the resident's hair was washed. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the resident should receive at least 2 baths a week and have her hair washed. 3. During an interview on 12/13/22 10:18 a.m., Resident H indicated he did not get 2 showers a week and has not had his hair washed. The resident's hair was visibly greasy during the interview The record for Resident H was reviewed on 12/16/22 at 10:00 a.m. Diagnoses included, but were not limited, depressive disorder, osteoarthritis, high blood pressure, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 12/3/22, indicated the resident was cognitively intact. He was an extensive assist with 2 person physical assist for bathing and extensive assist with 1 person physical assist for personal hygiene. A Care Plan, revised on 9/14/22, indicated the resident had a ADL self care deficit and required assistance with all ADLs. The shower sheets indicated the resident was to receive a shower on Wednesdays and Fridays. The resident did not receive a shower on 11/19 and 12/4/22. There was no documentation the resident's hair was washed at the time of the showers. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the resident was to have at least 2 showers a week. 4. During an interview on 12/13/22 2:30 p.m., Resident M indicated he did not get showers 2 times a week. He preferred to have a shower at night time before he went to bed because he slept better. The record for Resident M was reviewed on 12/19/22 at 10:15 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included but were not limited to, respiratory failure, tracheostomy, psychotic disorder, schizoaffective disorder, sleep apnea, high blood pressure, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 10/4/22, indicated the resident was cognitively intact, was independent and only needed set up help for bathing. A Care Plan, revised on 3/28/22, indicated the resident had an ADL self care deficit related to weakness and a decline in functional status. Physician's Orders, dated 9/29/22, indicated the resident was to have staff set him up in the shower before bed nightly per his request. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The shower sheets indicated the resident received a shower on 11/3, 11/8, 11/17, 11/22, 11/24, 11/29, 12/6, 12/10, and 12/17/22. His showers were not completed 2 times a week or nightly per request. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the resident should have at least 2 showers a week. 45666 5. During an interview with Resident P on 12/13/22 at 2:22 p.m., the resident indicated she had not had her hair washed in a very long time and it felt greasy. Resident P's record was reviewed on 12/16/22 at 10:25 a.m. Diagnoses included, but were not limited to, spondylosis of the lumbar region (degeneration of the spine), anxiety disorder, and depression. The Admission Minimum Data Set assessment, dated 11/25/22, indicated the resident was cognitively intact for daily decision making. The resident required physical help with one person physical assist for bathing and limited assistance for personal hygiene. The Shower/Bath Sheets indicated the resident received a complete bed bath on 11/21/22, 11/24/22, and 12/12/22. The type of shower or bath was not listed on 11/28/22, 11/30/22, 12/5/22, and 12/7/22. The Shower/Bath Sheets did not indicate the resident had her hair washed. Interview with the Nurse Consultant on 12/20/22 at 3:41 p.m., indicated she had no further information to provide. 6. Interview with Resident O on 12/13/22 at 10:51 a.m., indicated the resident wanted to be clean shaven. His toe nails were also long. On 12/15/22 at 11:34 a.m., Resident O indicated staff still had not shaved his face or cut his toenails. Resident O's record was reviewed on 12/15/22 at 11:39 a.m. Diagnoses included, but were not limited to, Parkinson's disease, chronic pain syndrome, and acute respiratory failure. The Discharge Minimum Data Set (MDS) assessment, dated 11/21/22, indicated the resident was cognitively intact for daily decision making. The resident required extensive assistance for personal hygiene, bed mobility, and dressing. A Care Plan, dated 8/12/22, indicated the resident had an activities of daily life (ADL) self care performance deficit and required assistance with ADLs. The Shower/Bath sheets indicated the resident received a bed bath on 11/17/22, 12/1/22, 12/6/22, 12/9/221, 12/13/22, and 12/15/22. The record lacked documentation the resident received nail care or assistance with shaving. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Nurse Consultant on 2/20/22 at 3:41 p.m., indicated she had no further information to provide. This Federal tag relates to Complaints IN00387079 and IN00390113. 3.1-38(a)(3)(B) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E) 3.1-38(b)(2)

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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** 45666 Based on observation, record review, and interview the facility failed to ensure a resident received timely treatment for a fractured shoulder, treatment was provided for a resident with complaints of constipation, and dry skin was assessed and treated for 1 of 1 residents reviewed for falls, 1 of 2 residents reviewed for constipation, and 1 of 1 residents reviewed for skin conditions non-pressure related. (Residents F, Q, and P) Findings include: 1. Resident F's record was reviewed on 12/14/22 at 9:53 a.m. Diagnoses included, but were not limited to, syncope and collapse, coronary artery disease, heart failure, and stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 11/26/22, indicated the resident was moderately impaired for daily decision making. Nurses' Notes, dated 8/14/22 at 7:40 a.m., indicated the resident was found on the floor sitting upright leaning back on the bed. The CNA who found the resident indicated the wheelchair was found in the hallway. The resident stated that his roommate moved the wheelchair from behind him and that was why he fell . The resident began to complain of left shoulder pain. The physician was notified and orders were received to have a STAT x-ray of the left shoulder and Tylenol for pain. Nurses' Notes, dated 8/14/22 at 5:13 p.m., indicated the writer called regarding the x-ray results. The results were not ready. Nurses' Notes, dated 8/14/2022 at 10:00 p.m., indicated the x-ray results were received of left shoulder with acute fracture noted, the physician was notified and a new order was received to send the resident to the hospital. Transportation was notified and stated the estimated time of arrival would be approximately 60 minutes. Nurses' Notes, dated 8/14/2022 at 11:24 p.m., indicated transportation arrived to take resident to the hospital. The x-ray examination was completed on 8/14/22 at 11:59 a.m. The x-ray results were reported on 8/14/22 at 5:11 p.m. Interview with the Nurse Consultant on 12/21/22 at 10:55 a.m., indicated she had no further information to provide. 2. During an interview with Resident P on 12/13/22 at 2:29 p.m., the resident indicated she had an ongoing problem with constipation since she arrived to the facility on [DATE]. Resident P's record was reviewed on 12/16/22 at 10:25 a.m. Diagnoses included, but were not limited to, spondylosis of the lumbar region (degeneration of the spine), anxiety disorder, and depression. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission Minimum Data Set assessment, dated 11/25/22, indicated the resident was cognitively intact for daily decision making. A Care Plan, dated 11/21/22, indicated the resident received an antidepressant medication. Interventions included, but were not limited to, observe for side effects of the medications such as constipation, weight change, headache, or urinary retention. A Care Plan, dated 11/21/22, indicated the resident received an antipsychotic medication. Interventions included, but were not limited to, observe for side effects of the medication such as constipation, dry mouth, and abnormal movements. A Care Plan, dated 11/21/22, indicated the resident received an anti-anxiety medication. Interventions included, but were not limited to, observe for side effects of the medication such as constipation, dry mouth, and urinary retention. The Bowel Movement task indicated the resident did not have any bowel movements on the following dates: 11/20/22, 11/21/22, 11/28/22, 11/30/22, 12/1/22, 12/2/22, 12/7/22, 12/8/22, 12/10/22, 12/12/22, 12/15/22, 12/17/22, and 12/19/22. The record lacked an order for a treatment for constipation. Interview with the Nurse Consultant on 12/20/22 at 3:41 p.m., indicated she would get an order for a laxative for the resident. 3. Interview with Resident Q on 12/14/22 at 10:19 a.m., indicated she had very dry toes on her left foot and the bottom of her right foot felt dry too. On 12/15/22 at 10:40 a.m., Resident Q indicated her toes were still very dry on her left foot. Resident Q's record was reviewed on 12/15/22 at 1:03 p.m. Diagnoses included, but were not limited to, high blood pressure and diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 11/28/22, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 12/1/22 at 2:00 p.m., indicated to monitor digits to the left upper extremity cast and left lower extremity cast for circulation, motor, and sensory changes. Notify the physician with changes in color, temperature, and appearance every shift. Interview with RN 1 on 12/16/22 at 11:12 a.m., indicated the resident did have very dry and scaly toes on the left foot and they should have been putting lotion on the resident after bathing. Interview with the Nurse Consultant on 12/20/22 at 3:41 p.m., indicated she had no further information to provide. This Federal tag relates to Complaint IN00390793. 3.1-37(a)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 10770 Based on observation, record review, and interview, the facility failed to ensure residents with impaired vision and hearing received the necessary services related to following up with referrals for hearing aids and eye glasses for 2 of 3 residents reviewed for vision and hearing. (Residents 48 and H) Findings include: 1. During an interview on 12/13/22 at 11:18 a.m., Resident 48 indicated he had seen both the ear and eye doctor months ago, and was still waiting on his hearing aids and eye glasses. The resident indicated, They even took molds of my ears for the hearing aids. The record for resident 48 was reviewed on 12/15/22 at 2:05 p.m. Diagnoses included, but were not limited to, type 2 diabetes, heart disease, and colon cancer. The Quarterly Minimum Data Set (MDS) assessment, dated 11/22/22, indicated the resident was cognitively intact. The resident's hearing was adequate and he had no hearing aides. The resident had clear speech and his vision was adequate and he had no corrective lenses. A Care Plan, revised on 7/13/22, indicated the resident had impaired visual function related to blurred vision and does not have glasses. The approaches were to arrange for consultation with eye care practitioner as required and follow up with ophthalmology/optometrist as needed. There was no Care Plan for hearing loss. The resident was seen by the Audiologist on 7/5/22. Clinical findings indicated the resident had a degree of hearing loss to both ears. Hearing aids were recommended and impressions were taken. A medical consult was recommended to obtain medical clearance for the hearing aids. The resident was seen by the eye doctor on 6/22/22. A recommendation for new glasses and bifocals was made upon approval. A glasses prescription was written at the time of visit. The Audiologist was in the facility on 7/5, 7/6, 7/20 and 10/26/22. The eye doctor was in the facility on 6/22, 6/23, 6/24, 7/1, 7/29, 9/9, 9/30, 10/6, and 11/2322. The resident was not seen by the Audiologist or the eye doctor for follow up after the initial recommendations. Interview with the Director of Nursing on 12/20/22 at 8:30 a.m., indicated the resident had not seen the eye doctor or the Audiologist since they both had made the recommendations for a new hearing aids and new glasses. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview with Resident H on 12/13/22 at 10:30 a.m., he indicated he was supposed to see the eye doctor and staff were supposed to get him up, but they could not find a hoyer pad so he was not seen. He had not seen the eye doctor or been told another appointment had been made for him. The record for Resident H was reviewed on 12/16/22 at 10:00 a.m. Diagnoses included, but were not limited, depressive disorder, osteoarthritis, high blood pressure, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 12/3/22, indicated the resident was cognitively intact. The resident's vision was adequate. There was no Care Plan for impaired vision. An eye doctor visit report on 7/29/22 indicated the resident was not treated due to refusal. The eye doctor was in the facility on 6/22, 6/23, 6/24, 7/1, 7/29, 9/9, 9/30, 10/6, and 11/2322. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the resident was not on the list each time the eye doctor had been in the facility since 7/29/22. 3.1-39(a)(1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 10326 Based on observation, record review, and interview, the facility failed to ensure pressure ulcers were covered as ordered for 1 of 2 residents reviewed for pressure ulcers. (Resident 8) Finding includes: On 12/16/22 at 3:44 a.m., Resident 8 was observed in her room in bed sleeping. A white gauze bandage was observed on the resident's left stump. At 9:14 a.m., the resident was in her room in bed. She was being assisted with breakfast and the bandage to the resident's left stump was not observed. At 10:31 a.m., the resident was seated in a broda chair across from the nurses' station. She was taken back to her room for a skin assessment by LPN 1. The LPN rolled up the resident's left pant leg and the bandage to the left stump was not visible. She proceeded to elevate the resident's upper leg and the gauze dressing was stuck together and dangling from the stump area. The resident's wound was not covered at that time. The LPN then unfolded the dressing and covered the pressure area. The record for Resident 8 was reviewed on 12/15/22 at 3:13 p.m. Diagnoses included, but were not limited to, acquired absence of the left leg below the knee, type 2 diabetes, and dementia without behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 11/16/22, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. She needed extensive assistance with bed mobility and was total assist for transfers. The resident had one Stage 3 pressure ulcer. A Care Plan, dated 10/12/22, indicated the resident was at risk for pressure ulcer development, impaired skin integrity, or at risk for altered skin integrity related to cognitive status, weakness, and incontinence. She had left knee trauma and a pressure ulcer to the left stump. Interventions included, but were not limited to, administer treatments as ordered by the medical provider. A Physician's Order, dated 11/2/22, indicated the left stump was to be cleansed every day shift with either normal saline or wound cleanser. Collagen was to be applied to the wound bed and the area covered with a dry dressing. The dressing could be changed as needed (prn) for soilage. Wound measurements, dated 12/12/22, indicated the area to the left stump was a Stage 3 and measured 1. 18 centimeters (cm) x 1.28 cm with undermining of 0.4 cm at 5-10 o'clock . Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated the area to the resident's left stump should have been covered and a new dressing applied. 3.1-40(a)(2)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. 45666 Based on interview and record review, the facility failed to ensure a nephrostomy was monitored as ordered for 1 of 2 residents reviewed for catheters. (Resident O) Finding includes: The record for Resident O was reviewed on 12/15/22 at 11:39 a.m. Diagnoses included, but were not limited to, obstructive uropathy, Parkinson's disease, and acute respiratory failure. The Discharge Minimum Data Set (MDS) assessment, dated 11/21/22, indicated the resident was cognitively intact for daily decision making. The resident had an indwelling catheter and required extensive assistance for activities of daily living. A Care Plan, dated 9/1/22, indicated the resident had a right nephrostomy tube and foley catheter in place due to obstructive uropathy, renal calculus, and urine retention. A Physician's Order, dated 12/1/22, indicated to measure ostomy output every shift for nephrostomy care. The Treatment Administration Record for December 2022 lacked documentation of output from the nephrostomy on the following days and shifts: - 12/1/22: days and evenings - 12/3/22: days - 12/4/22: days and evenings - 12/5/22: days and evenings - 12/6/22: days and nights - 12/7/22: nights - 12/8/22: nights - 12/12/22: days - 12/13/22: days - 12/14/22: nights Interview with the Nurse Consultant on 12/20/22 at 3:41 p.m., indicated she had no further information to provide. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-47(a)(3)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 10770 Based on observation, record review, and interview, the facility failed to ensure acceptable parameters of nutrition were maintained related to not following the Registered Dietitian's (RD) recommendations timely which resulted in a significant weight loss for a resident who was NPO and only receiving an enteral feeding. The facility also failed to ensure food consumption was documented for residents with a history of weight loss for 5 of 7 residents reviewed for nutrition. (Residents 89, 24, N, 5, and 8) Findings include: 1. On 12/12/22 at 9:37 a.m., Resident 89 was observed sitting in a wheelchair in her room. At that time, there was an enteral tube feeding of Jevity infusing at 45 cubic centimeters (cc) per hour. On 12/16/22 at 5:30 a.m., the resident was observed in bed. The tube feeding had been disconnected. At 8:03 a.m., LPN 1 was observed to hang a new bottle of the enteral feeding. The record for Resident 89 was reviewed on 12/15/22 at 3:00 p.m. Diagnoses, included but were not limited to, multiple sclerosis, dysphagia, dementia with behaviors, schizophrenia, peg tube, and depressive disorder. The Annual Minimum Data Set (MDS) assessment, dated 12/7/22, indicated the resident was moderately impaired for decision making. The resident weighed 105 pounds and had significant weight loss. She received greater than 51% of fluid intake and calories every day through the peg tube. The Care Plan, revised on 12/14/22, indicated the resident required a tube feeding. The resident's weights were as follows: 7/7/22 - 129 pounds 8/16/22 - 129 pounds 9/2/22 - 108 pounds 10/2/22 - 112 pounds 10/17/22 - 112 pounds 11/13/22 - 105 pounds 12/19/22 - 101 pounds (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	An RD Progress Note, dated 10/19/22 at 3:06 p.m. and 10/20/22 at 12:47 p.m., indicated the resident was NPO and received all nutrition via peg tube. The current tube feeding order of Jevity 1.2 at 35 cc per hour provided 42 grams of protein, 924 Kcal, and 1521 of water. RD recommended to discontinue current enteral nutrition order and current tube feed flush order. RD recommended Fibersource HN at 45 cc per hour times 22 hours. This would provide 990 milliliters (ml) of total volume, 1188 kcal, 53 grams of protein. RD recommended to flush with 125 ml of water every 4 hours. A RD Progress Note, dated 11/17/22 at 2:54 p.m., indicated the resident was NPO and received all nutrition via peg tube. The current tube feeding order of Jevity 1.2 at 35 cc per hour provided 42 grams of protein, 924 Kcal, and 1521 of water. The resident presented with a with a significant weight loss of 6.3% times 30 days. RD recommended Fibersource HN at 45 cc per hour times 22 hours. This would provide 990 milliliters (ml) of total volume, 1188 kcal, 53 grams of protein. RD recommended to flush with 125 ml of water every 4 hours. Physician's Orders, dated 3/25/22 and discontinued 10/8/22, indicated Enteral feed of Jevity 1.2 at 50 cc per hour times 22 hours. Physician's Orders, dated 10/9/22 and discontinued 11/17/22, indicated Enteral feed Jevity 1.2 at 35 cc per hour times 22 hours. Off at 6:00 a.m., and on at 8:00 a.m. Physician's Orders, dated 11/18/22 and discontinued 12/5/22, indicated Enteral feed Fibersource HN at 45 cc per hour times 22 hours. Off at 6 a.m., and on at 8 a.m. Physician's Orders, dated 10/20/22, indicated Fibersource HN - may substitute if Jevity 1.2 & Jevity 1.5 unavailable. Infuse at same rate per order. Physician's Orders, dated 12/6/22, indicated Enteral feed of Jevity 1.2 at 45 cc per hour times 22 hours. Off at 6:00 a.m., and on at 8:00 a.m. The Medication Administration Record (MAR) for the months of 10/2022 and 11/2022 indicated the Jevity 1.2 at 35 cc per hour was signed out as being administered 10/9-10/31/22 and 11/1-11/17/22. The tube feeding was flushed every 4 hours with 150 cc of water from 10/1-10/31/22 and 11/1-11/17/22. Jevity at 35 cc per hour was signed out as being substituted for the Fibersource HN on 10/20, 10/21, 10/24, 10/27-10/30/22 and on 11/2-11/4, 11/7, 11/10-11/13, and 11/16-11/17/22. Interview with the RD on 12/19/22 at 3:35 p.m., indicated she had made the recommendation for the tube feeding increase and for a different formula. The recommendation was not acted upon for 1 month. She documented her recommendations on a paper and it was up to the nursing staff to follow through with the orders. Interview with the Nurse Consultant on 12/21/22 at 8:15 p.m., indicated there were no other weights obtained during the months of November or December 2022 and the RD's recommendation was not acted upon in a timely manner. (continued on next page)

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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 0692 Level of Harm - Actual harm Residents Affected - Few	2. On 12/13/22 at 3:00 p.m., Resident 24 was observed in bed. At that time, the enteral feeding was turned off and not infusing. On 12/14/22 at 9:30 a.m., the resident was observed in bed and enteral feeding was infusing at 55 cubic centimeters (cc) per hour. On 12/16/22 at 5:30 a.m., the resident was observed in bed. The tube feeding had been disconnected. At 8:05 a.m., LPN 1 was observed to hang a new bottle of the enteral feeding. The record for Resident 24 was reviewed on 12/16/22 at 5:00 a.m. Diagnoses included but were not limited to, encephalopathy, quadriplegia, epilepsy, anxiety, and peg tube. The Modification of the Quarterly Minimum Data Set (MDS) assessment, dated 9/30/22, indicated the resident was not cognitively intact. The resident weighed 148 pounds and had a significant weight loss. A Care Plan, revised on 11/28/22, indicated the resident was NPO and required tube feeding. The approaches were to provide enteral feeding per physician diet orders and the RD will evaluate quarterly and as needed and make recommendations for changes to tube feeding as needed. The resident's weights were as follows: 8/16/22 199 pounds 9/2/22 148 pounds 10/2/22 146 pounds 10/3/22 146 pounds 10/4/22 146 pounds 11/13/22 142 pounds 12/14/22 145 pounds A RD Quarterly Assessment, dated 11/28/22, indicated the resident presented with a significant weight loss of 28.5% times 90 days (8/16-11/13/22). The resident was NPO and had an open wound on the right second toe. Recommendations were to discontinue current tube feed order and start Fibersource HN at 65 cc times 22 hrs. Interview with the Registered Dietitian on 12/19/22 at 3:35 p.m., indicated she made the recommendation for the tube feeding increase and it had not been acted upon as of yet. She documented her recommendations on a paper and it was up to the nursing staff to follow through with the orders. Physician's Orders, dated 11/17/22, indicated Fibersource HN at 55 cc per hour times 22 hours. Off at 6:00 a.m., and on at 8:00 a.m. Water flush of 125 cc every 4 hours per peg tube. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the RD was going to reassess the resident's nutritional status. 3. The record for Resident N was reviewed on 12/16/22 at 6:50 a.m. Diagnoses included, but were not limited to, stroke, type 2 diabetes, chronic kidney disease, heart failure, depressive disorder, atrial fibrillation, altered mental status, and high blood pressure. The Quarterly, 10/23/22 Minimum Data Set (MDS) assessment, indicated the resident was not alert and oriented and was severely impaired for decision making. The resident was an extensive assist with a 1 person assist for personal hygiene and totally dependent on staff for bathing. The resident weighed a 126 pounds and had significant weight loss. A Care Plan, revised on 10/12/22, indicated the resident had a nutritional problem. The approaches were to monitor meal intake. The resident's weights were as follows: 8/1/22 178 pounds 9/4/22 177 pounds 10/10/22 126 pounds 10/18/22 126 pounds 10/20/22 127 pounds 10/24/22 128 pounds 10/27/22 128 pounds 11/3/22 128 pounds 12/14/22 128 pounds An Admission RD Assessment, dated 10/12/22, indicated the resident presented with a significant weight loss of 28.8% x 30 days (10/10/22 vs 9/4/22). The resident received a regular diet. Recommendations to continue weekly weights. The meal consumption for the last 30 days indicated no meals were documented on 11/18-11/20, 11/23, 11/24, 11/26, 11/27, 11/30, 12/4, 12/6-12/10, 12/14, and 12/15/22. Breakfast was not documented on 11/17, 11/21, 11/22, 11/25, 12/5, and 12/11/22. Lunch was not documented on 11/17, 11/21, 11/22, 11/25, 12/5, and 12/11/22. Dinner was not documented on 12/3 and 12/12/22. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the meal consumption intakes were incomplete. 10326 4. The record for Resident 5 was reviewed on 12/19/22 at 9:48 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), urinary tract infection, and schizoaffective disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/17/22, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. She required extensive assistance with eating and received a mechanically altered diet. A Physician's Order, dated 12/8/22, indicated the resident was to receive a pureed diet with nectar thick liquids. A revision on 12/14/22, indicated the resident could have soft foods with supervision. Dietary Progress Notes, dated 12/1/22 at 4:44 p.m., indicated the resident was being followed in Nutrition at Risk (NAR) for readmission on 11/15/22. The resident was currently NPO (nothing by mouth) and was receiving a tube feed bolus. The resident presented with a significant weight loss of 38.9% times 60 days. Her current weight was stable with a gradual weight gain of 4.5% times 45 days. Continue with current nutritional plan. Dietary Progress Notes, dated 12/9/22 at 12:49 p.m., indicated the resident was being followed in Nutrition at Risk (NAR) for readmission on 11/15/22. Her current diet order was a regular diet with puree texture and continue with tube feed order of Jevity 1.5 bolus four times a day. The resident presented with a weight gain of 4.3% in 7 days. The weight gain was desired related to a history of weight loss. Continue to follow in NAR. The food consumption logs, dated 12/8-12/18/22, indicated there was no meal consumption documented on 12/13, 12/17, and 12/18/22. No breakfast was documented on 12/15/22 and no dinner was documented on 12/11 and 12/14/22. Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated the food consumption logs should have been completed based on the resident's history of weight loss. 5. The record for Resident 8 was reviewed on 12/15/22 at 3:13 p.m. Diagnoses included, but were not limited to, acquired absence of the left leg below the knee, type 2 diabetes, and dementia without behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 11/16/22, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. She required extensive assistance with eating and received a mechanically altered diet. A Care Plan, dated 10/12/22, indicated the resident was at nutritional risk related to a history of diabetes, hypertension, cognitive status, weight loss, and impaired skin integrity. Interventions included, but were not limited to, monitor daily intakes. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The 12/2022 Physician's Order Summary (POS), indicated the resident was to receive a pureed diet. The food consumption log, dated 11/16 - 12/16/22, indicated no meal consumption was documented on 11/25, 11/28, 12/3, 12/4, 12/5, 12/6, 12/8, and 12/9/22. No breakfast or lunch was documented on 11/24, 11/26, 12/11, and 12/12/22. No dinner was documented on 11/17, 11/19, 11/20, 11/21, 11/29, 12/1, and 12/15/22. Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated the food consumption logs should have been completed based on the resident's history of weight loss. 3.1-46(a)(1)

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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. 10326 Based on observation, record review, and interview, the facility failed to ensure a resident's tube feeding was infusing at the correct time for 1 of 1 residents reviewed for tube feeding. (Resident 85) Finding includes: On 12/13/22 at 11:00 a.m., Resident 85 was observed in his room in bed. His tube feeding pump was turned off. On 12/14/22 at 11:06 a.m., the resident was observed in his room in bed with the tube feeding pump turned off. On 12/15/22 at 9:47 a.m., the resident's tube feeding was infusing at 35 cubic centimeters (cc's) per hour. At 11:45 a.m. and 1:09 p.m., the resident was seated in his wheelchair in the main dining room. He was disconnected from his tube feeding. At 2:54 p.m., the resident was in his room watching television. The tube feeding remained disconnected and the pump was turned off. On 12/16/22 at 3:47 a.m., the resident was in his room in bed watching television. His tube feeding was infusing at 35 cc/hr. At 5:47 a.m., the feeding pump was turned off and the tube feeding bag had been removed from the pole. At 8:17 a.m. and 10:31 a.m., the resident's tube feeding was infusing at 35 cc/hr. On 12/17/22 at 9:17 a.m., the resident's tube feeding was infusing at 35 cc/hr. The record for Resident 85 was reviewed on 12/15/22 at 11:21 a.m. Diagnoses included, but were not limited to, stroke and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 10/8/22, indicated the resident was moderately impaired for decision making and he needed extensive assistance with eating. He had a feeding tube and received a mechanically altered diet. The Care Plan, dated 9/19/22, indicated the resident was at nutritional risk related to needing a tube feeding to aid in meeting his nutrition needs. Interventions included, but were not limited to, provide tube feeding per medical provider orders. A Physician's Order, dated 10/1/22, indicated the resident was to receive Glucerna 1.2 at 35 cc/hr for 20 hrs via his feeding tube. There was no documentation indicating when the tube feeding was to be turned on and off. There was also no documentation on the 12/2022 Medication and Treatment Administration Records indicating what time the tube feeding was to be turned on and off. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated a clarification order needed to be obtained. 3.1-44(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on observation, record review, and interview, the facility failed to ensure signs and symptoms of upper respiratory infections were monitored after medication was initiated, orders were obtained for oxygen and it was set at the correct flow rate, and tracheostomy care was monitored for 5 of 7 residents reviewed for respiratory services. (Residents 64, 85, S, E, and M) Findings include: 1. Interview with Resident 64 on 12/13/22 at 11:06 a.m., indicated she had a cough and was recently started on nebulizer treatments. The record for Resident 64 was reviewed on 12/16/22 at 8:27 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 11/16/22, indicated the resident was cognitively intact. A Physician's Order, dated 12/13/22, indicated the resident was to receive Albuterol Sulfate Inhalation Nebulization Solution 2.5 milligrams/3 milliliters 0.083%, 1 vial inhale orally every 6 hours as needed for shortness of breath, wheezing, and coughing. Nurses' Notes, dated 11/21/22 at 11:08 a.m., indicated the resident was complaining of nasal congestion and a nonproductive cough was noted. A new order was obtained to start Fluticasone Propionate Nasal Suspension 50 micrograms daily. The next entry in the Nurses' Notes was on 11/27/22. Nurses' Notes, dated 11/27/22 at 11:28 a.m., indicated the resident was complaining of shortness of breath, wheezing, and a nonproductive cough. As needed Albuterol and guaifenesin (a medication for chest congestion) were given as ordered. Oxygen was applied at 2 liters per nasal cannula. Nurses' Notes, dated 11/28/22 at 1:50 p.m., indicated the resident was complaining of coughing and chest congestion. The Physician was in the facility and a new order was received for Prednisone (a steroid) 20 mg daily for 5 days. The next entry in the Nurses' Notes was on 12/13/22. Nurses' Notes, dated 12/13/22 at 2:58 p.m., indicated the resident continued to smoke outside with a harsh cough, new orders were received to start as needed (prn) nebulizer treatments. Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated follow up documentation should have been completed. 2. The record for Resident 85 was reviewed on 12/15/22 at 11:21 a.m. Diagnoses included, but were not limited to, stroke and chronic obstructive pulmonary disease (COPD). The Quarterly Minimum Data Set (MDS) assessment, dated 10/8/22, indicated the resident was moderately impaired for daily decision making. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's Orders, dated 12/2/22, indicated the resident was to receive Diabetic Tussin EX Syrup (cough syrup), give 10 milliliters (ml) every 4 hours as needed (prn) for cough and Azithromycin (an antibiotic) tablet 250 milligrams (mg), give 2 tablets by mouth one time only for infection/cough then 250 mg, 1 tablet for 4 days. Nurses' Notes, dated 12/2/22 at 1:20 p.m., indicated the resident was complaining of pain and discomfort when he coughed. No active cold symptoms were noted at the time. The Physician was updated and new orders were received for a Zpac (Azithromycin) and prn cough syrup. The next entry in the Nurses' Notes was on 12/9/22 related to Nutrition at Risk. There was no additional documentation in the Nurses' Notes or skilled documentation notes since the antibiotic was initiated. Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated follow up documentation should have been completed. 10770 3. On 12/13/22 at 10:00 a.m. and 2:54 p.m., and on 12/14/22 at 9:25 a.m. and at 11:50 a.m., Resident S was observed in bed. At those times, the resident was wearing oxygen per nasal cannula. The flow rate was greater than 3.5 liters but not above 4 liters. The tubing was dated 12/2/22 as well as the nebulizer face mask on the night stand. The record for the resident was reviewed on 12/15/22 at 11:25 a.m. Diagnoses included, but were not limited to, congestive heart failure, chronic respiratory failure, stroke, COPD, type 2 diabetes, sleep apnea, and bradycardia. The Annual Minimum Data Set (MDS) assessment, dated 10/12/22, indicated the resident was cognitively intact and used oxygen. The Care Plan, revised on 10/18/22, indicated the resident had Chronic Obstructive Pulmonary Disease (COPD) with shortness of breath while lying flat. The approaches were to provide oxygen therapy as ordered and change tubing per facility policy. Physician's Orders, dated 9/22/22, indicated oxygen at 3 liters via nasal cannula continuously every shift for shortness of breath. Physician's Orders, dated 11/3/22, indicated change oxygen tubing and humidifier bottle every week and as needed one time a day every Thursday. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the oxygen was to be at 3 liters per nasal cannula and the tubing was to be changed weekly. 4. On 12/13/22 at 11:00 a.m., on 12/14 at 10:54 a.m., on 12/15 at 9:41 a.m., 11:30 a.m., 1:10 p.m., and 3:00 p.m., and on 12/16 at 6:40 a.m. and 10:00 a.m., Resident E was observed in bed. At those times she was wearing oxygen per nasal cannula at 5 liters per minute. There was no date on the oxygen tubing. On 12/19/22 at 9:10 a.m., the resident was observed in bed wearing oxygen per nasal cannula at 2.5 liters per minute. There was no date on the tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The record for Resident E was reviewed on 12/15/22 at 10:00 a.m. Diagnoses included, but were not limited to, COPD, bipolar disorder, anxiety, major depressive disorder, unspecified dementia with behavioral disturbances, schizophrenia, and dependence on oxygen. The Quarterly Minimum Data Set (MDS) assessment, dated 10/14/22, indicated the resident was cognitively intact. She was totally dependent on staff with 1 person physical assist for bathing and did not use oxygen. A Care Plan, revised on 2/1/22, indicated the resident had Chronic Obstructive Pulmonary Disease (COPD) with shortness of breath while lying flat. The approaches were to provide oxygen therapy as ordered and change tubing per facility policy. There were no Physician's Orders for the oxygen Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated there were no orders for oxygen for the resident. 5. During an interview with Resident M on 12/13/22 at 2:40 p.m., he indicated he was able to do his own tracheostomy care. He changed the inner cannula when it needed to be done. It was not done every day. He cleaned the actual trach and changed it out every month. He soaked the old trach in a bleach and water mixture until he was ready to change it. He walked to the bathroom and pointed to a clear cylinder with a lid over it and inside was a white plastic tracheostomy piece floating in the water. The resident indicated nursing staff do nothing with his tracheostomy as he took care of it himself. The record for Resident M was reviewed on 12/19/22 at 10:15 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included but were not limited to, respiratory failure, tracheostomy, psychotic disorder, schizoaffective disorder, sleep apnea, high blood pressure, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 10/4/22 indicated the resident was cognitively intact and had a tracheostomy. A Care Plan, revised on 4/8/22, indicated the resident had a tracheostomy in place due to respiratory failure. The approaches were to provide trach care as ordered. Physician's Orders, dated 4/12/22, indicated change trach ties one time a week and prn. Trach care every shift. The 11/2022 and 12/2022 Treatment Administration Records indicated all the trach care was signed out by nursing staff as being completed. Interview with LPN 1 on 12/19/22 at 11:00 a.m., indicated the resident does his own trach care. He transferred from the east unit, so she was unsure how long that had been going on. She had never seen him do his trach care nor had she done his trach care. She had not assessed the trach or the stoma on a daily basis when she worked. There was no self assessment for the resident to do his own trach care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing on 12/20/22 at 8:30 a.m., indicated the resident did not have a self assessment to perform his own trach care. The nursing staff were supposed to be assessing the trach and making sure the care was completed. Interview with the Nurse Consultant on 12/20/22 at 8:30 a.m., indicated the resident's trach had been discontinued as well as the inner cannula. The resident refused for staff to put a new trach in. The facility was going to set up another appointment with the ENT Doctor and have him replace the trach. 3.1-47(a)(4) 3.1-47(a)(6)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 45666 Based on interview and record review, the facility failed to ensure pain was effectively monitored for a resident with complaints of pain and a resident receiving pain medications for 2 of 2 residents reviewed for pain. (Residents F and P) Findings include: 1. During an interview with Resident F on 12/14/22 at 9:59 a.m., the resident had complaints of pain to his hand that were not being addressed. During an interview on 12/16/22 at 1:15 p.m., Resident F complained of pain to his hand and rated his pain a 9 out of 10 on the pain scale and requested to have his nurse bring him something for pain. Resident F's record was reviewed on 12/16/22 at 12:08 p.m. Diagnoses included, but were not limited to syncope and collapse, heart failure, diabetes mellitus, and respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 11/26/22, indicated the resident was moderately impaired for daily decision making. A Physician's Order, dated 6/7/22, indicated to monitor for pain every shift. The December 2022 Medication and Treatment Administration Record (MAR/TAR) indicated the resident did not have pain accurately assessed each shift. Interview with RN 1 on 12/16/22 at 1:18 p.m. indicated the order for the pain scale must have been entered incorrectly because there should have been a numeric pain scale to complete on the MAR/TAR. Interview with the Nurse Consultant on 12/20/22 at 3:41 p.m., indicated she would be changing the way they enter the pain scales on the MAR/TAR so it reflects a numeric pain scale. 2. Interview with Resident P on 12/13/22 at 2:19 p.m., indicated the resident received pain medications but she was still in pain. Resident P's record was reviewed on 12/16/22 at 10:25 a.m. Diagnoses included, but were not limited to, spondylosis of the lumbar region (degeneration of the spine), anxiety disorder, and depression. The Admission Minimum Data Set assessment, dated 11/25/22, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 11/18/22 at 4:30 p.m., indicated Acetaminophen 325 milligrams (mg) two tablets every six hours as needed for pain or fever. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order, dated 11/18/22 at 9:00 p.m., indicated Gabapentin 300 mg one capsule by mouth two times a day for nerve pain. A Physician's Order, dated 11/18/22 at 5:00 p.m., indicated Hydrocodone-acetaminophen 5-325 mg, 1 tablet by mouth every 6 hours as needed for pain. A Physician's Order, dated 11/18/22 at 10:00 p.m., indicated to monitor for pain every shift. The December 2022 Medication and Treatment Administration Record (MAR/TAR) indicated the resident did not have an accurate pain evaluation completed each shift. Interview with the Nurse Consultant on 12/20/22 at 3:41 p.m., indicated she would be changing the way they enter the pain scales on the MAR/TAR so it reflects a numeric pain scale. 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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 10326 Based on record review and interview, the facility failed to ensure a dialysis access site was assessed for 1 of 2 residents reviewed for dialysis. (Resident B) Finding includes: The record for Resident B was reviewed on 12/19/22 at 9:39 a.m. Diagnoses included, but were not limited to, end stage renal disease, stroke, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 11/11/22, indicated the resident was moderately impaired for daily decision making and he received dialysis while a resident of the facility. A Care Plan, reviewed on 11/8/22, indicated the resident had direct access to his circulatory system related to having a right subclavian permacath (dialysis access site). Interventions included, but were not limited to, evaluate for signs and symptoms of infection: redness, tenderness, swelling, pain, and drainage. Report abnormal findings to the medical provider, resident, and resident's representative. A Physician's Order, dated 11/10/22, indicated to check the dialysis site (right chest) for signs and symptoms of infection every shift. The order had not been transcribed onto the 11/2022 and 12/2022 Medication and Treatment Administration Records (MAR's and TAR's) and there was no other documentation in the resident's record. Interview with the Director of Nursing on 12/19/22 at 2:00 p.m., indicated the resident had a perma cath and it was assessed in dialysis. She indicated the order should have been carried over onto either the MAR or TAR and the perma cath assessed every shift as ordered. 3.1-37(a)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. 10326 Based on record review and interview, the facility failed to manage medications appropriately related to ensuring blood pressure and heart rate parameters were monitored prior to giving blood pressure medication, administering medications as ordered, and holding insulin with no Physician's Order for 4 of 5 residents reviewed for unnecessary medications. (Residents B, S, C, and Q) Findings include: 1. The record for Resident B was reviewed on 12/19/22 at 9:39 a.m. Diagnoses included, but were not limited to, end stage renal disease, stroke, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 11/11/22, indicated the resident was moderately impaired for daily decision making and he received dialysis while a resident of the facility. A Physician's Order, dated 12/12/22, indicated the resident was to receive Metoprolol Tartrate (a cardiac medication) Oral Tablet 25 milligrams (MG) by mouth twice a day for blood pressure. Hold the medication if the systolic blood pressure (top number) was less than 100 or heart rate less than 60. The 12/2022 Medication Administration Record (MAR) indicated there was no documentation that the resident's blood pressure or heart rate had been checked prior to giving the medication from 12/12 to current. Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated the resident's blood pressure and heart rate should have been documented on the MAR. 10770 2. The record for Resident S was reviewed on 12/15/22 at 11:25 a.m. Diagnoses included, but were not limited to, congestive heart failure, chronic respiratory failure, stroke, COPD, type 2 diabetes, sleep apnea, and bradycardia. The Annual Minimum Data Set (MDS) assessment, dated 10/12/22, indicated the resident was cognitively intact and used oxygen as a resident. Physician's Orders, dated 10/28/22, indicated Midodrine HCl tablet 10 milligrams (mg). Give 1 tablet by mouth every morning and at bedtime for low blood pressure and hold if SBP (Systolic Blood Pressure - top number) is greater than 120. Metoprolol Tartrate tablet 25 mg. - give 12.5 mg by mouth every morning and at bedtime for high blood pressure. Hold if SBP is less than 100 or DBP (Diastolic Blood Pressure - bottom number) is less than 60. Physician's Orders, dated 9/22/22, indicated Insulin Glargine 100 units/milliliter. Inject 30 units subcutaneously at bedtime. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Medication Administration Record (MAR) for the month of 11/2022 indicated the Insulin 30 units was not signed out as being administered on 11/12, 11/19, 11/26, and 11/29/22 The Metoprolol and Midodrine was not signed out as being administered on 11/12, 11/19 and 11/29/22 for the 9:00 p.m. dose. The Midodrine was administered on 11/10 at 8:00 a.m., (blood pressure was 144/78), on 11/15 (blood pressure was 142/75), and on 11/20/22 (blood pressure was 130/80). The medication was signed out as being administered for the 9:00 p.m. dose on 11/9 (blood pressure was 121/75), on 11/10 (blood pressure was 125/74), 11/17 (blood pressure was 122/84), and 11/24/22 (blood pressure was 129/78). 12/2022 MAR indicated the Midodrine was signed out as being administered at 8:00 a.m., on 12/6 (blood pressure was 124/87) and on 12/9/22 (blood pressure was 126/70). The 9:00 p.m. dose was held on 12/2/22 and blood pressure was 120/68. The medication was administered on 12/11/22 at 9:00 p.m., and the blood pressure was 128/76. The Midodrine was not signed out as being administered on 12/8/22 at 9:00 p.m. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the blood pressure medications were blank and/or given when they should have been held. 3. During an interview on 12/13/22 at 2:10 p.m., Resident C indicated she did not get her medications on time and sometimes she had missed her medications, including blood pressure medications and insulin. The record for Resident C was reviewed on 12/20/22 at 12:15 p.m. Diagnoses included, but were not limited to, heart failure, renal dialysis, type 2 diabetes, high blood pressure and heart disease. The Quarterly Minimum Data Set (MDS) assessment, dated 11/15/22, indicated the resident was cognitively intact. The 9/2022 Medication Administration Record (MAR) indicated the following medications were not signed out being administered at 8:00 p.m. on 9/6/22 - Glipizide 5 mg (milligrams) - Gabapentin 100 mg - Coreg 3.125 mg - Bumetanide 1 mg - Atorvastatin 40 mg The 11/2022 MAR indicated the following medications were not signed out as being administered on 11/12/22 at 8:00 p.m. - Atorvastatin 40 mg (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Refresh Optive Advanced Ophthalmic 2 drop in both eyes - Bumetanide 1 mg 2 tabs - Coreg 3.125 mg - Gabapentin 100 mg - Glipizide 5 mg Interview with the Nurse Consultant on 12/21/22 at 8:15 a.m., indicated the medications were not signed out as being administered. 45666 4. Resident Q's record was reviewed on 12/15/22 at 1:03 p.m. Diagnoses included, but were not limited to, high blood pressure and diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 11/28/22, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 11/22/22 at 9:00 a.m., indicated Insulin Glargine pen 100 unit/milliliter, inject 15 units subcutaneously in the morning. The December 2022 Medication Administration Record (MAR) indicated the dose of Insulin Glargine was not marked as administered at 9:00 a.m. on 12/1/22 with a blood sugar of 119, 12/6/22 with no blood sugar listed, or 12/6/22 with no blood sugar listed. There were no orders or parameters to hold the insulin Glargine. A Physician's Order, dated 11/29/22 at 8:00 a.m., indicated Macrobid (an antibiotic) 100 mg, give one capsule two times a day until 12/6/22. The December 2022 Medication Administration Record (MAR) indicated the Macrobid was not administered on 12/3/22 at 5:00 p.m., 12/4/22 at 8:00 a.m., 12/5/22 8:00 a.m. and 5:00 p.m., 12/6/22 at 8:00 a.m. and 5:00 p.m. Interview with the Nurse Consultant on 12/20/22 at 3:41 p.m., indicated she had no further information to provide. This Federal tag relates to Complaint IN00388811 and IN00388985. 3.1-48(a)(6)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 10326 Based on record review and interview, the facility failed to ensure AIMS (Abnormal Involuntary Movement, a rating scale that was designed to measure involuntary movements known as tardive dyskinesia) scales were completed and side effects for antipsychotic medications were monitored for 2 of 5 residents reviewed for unnecessary medications. (Residents 12 and E) Findings include: 1. The record for Resident 12 was reviewed on 12/15/22 at 9:59 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 12/6/22, indicated the resident was moderately impaired for daily decision making and she received an antipsychotic medication on a routine basis. A Care Plan, dated 9/9/22, indicated the resident had a mood problem related to being bipolar and having a mood disorder. Interventions included, but were not limited to, administer medications as ordered. Observe and document signs and symptoms of effectiveness and side effects. A Care Plan, dated 9/5/22, indicated the resident received an antipsychotic medication Risperdal related to having bipolar and mood disorder. Interventions included, but were not limited to, complete AIMS test per company process and observe for side effects of the antipsychotic medication. A Physician's Order, dated 11/23/22, indicated the resident was to receive Risperidone (Risperdal - an antipsychotic medication) 0.25 milligrams (mg) one time a day for bipolar disorder. There was no order to monitor for medication side effects. There was no documentation on the November and December 2022 Medication Administration Records (MAR's) where the resident was being monitored for side effects. There was no AIMS scale available for review. Interview with the Director of Nursing on 12/19/22 at 1:25 p.m., indicated the resident should have been monitored for medication side effects and an AIMS scale should have been completed upon admission. 10770 2. The record for Resident E was reviewed on 12/15/22 at 10:00 a.m. Diagnoses included, but were not limited to, COPD, bipolar disorder, anxiety, major depressive disorder, unspecified dementia with behavioral disturbances, schizophrenia, and dependence on oxygen. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS) assessment, dated 10/14/22, indicated the resident was cognitively intact. In the last 7 days the resident received an antipsychotic medication 7 times, anti-anxiety medication 7 times, and antidepressant medication 7 times. A Care Plan, revised on 2/1/22 indicated the resident used anti-anxiety medication, antipsychotic medication and antidepressant medication. The approaches were to observe for side effects of each of the medications. Physician's Orders, dated 4/7/22 and updated 9/11/22, indicated Lorazepam (an anti-anxiety medication) 0.5 milligrams (mg). Give 0.5 mg by mouth three times a day for anxiety. Physician's Orders, dated 4/7/22 and updated 5/9/22, indicated Risperidone (an antipsychotic medication) 0. 25 mg. Give 0.25 mg by mouth two times a day for bipolar schizophrenia. Physician's Orders, dated 4/7/22, indicate Bupropion (an antidepressant medication) HCl ER (XL) 300 mg. Give 1 tablet by mouth one time a day for depression. The 11/2022 and 12/2022 Medication Administration Record (MAR) indicated there was no documentation of the monitoring of signs and symptoms of side effects for the psychotropic medication. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated documentation of monitoring the side effects of the psychotropic medication was lacking in the clinical record. 3.1-48(a)(3)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 10326 Based on observation, record review, and interview, the facility failed to ensure a resident was free from significant medication errors related to not priming an insulin pen prior to administration for 1 of 5 residents observed during medication pass. (Resident 40) Finding includes: On 12/19/22 at 9:00 a.m., LPN 2 was observed preparing medications for Resident 40. She had checked the resident's blood sugar and it was 221, the LPN indicated the resident was going to receive 19 units of Novolog (a fast acting insulin) based on her routine order and her sliding scale order. The LPN dialed the Novolog flex pen to 19 units. She proceeded to enter the residents room, she sanitized her hands, donned gloves, wiped the resident's left upper arm with an alcohol pad and then she administered the insulin. She did not prime the insulin pen prior to giving the resident her dose. The record for Resident 40 was reviewed on 12/19/22 at 10:00 a.m. Diagnoses included, but were not limited to, type 2 diabetes and heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 11/28/22, indicated the resident was moderately impaired for daily decision making and she received insulin. The December 2022 Physician's Order Summary (POS), indicated the following: Insulin Aspart Solution Pen-injector 100 UNIT/ML Inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units above 400 or below 60 call the Physician, subcutaneously three times a day for diabetes inject 2-10 units into the skin three times a day (3 milliliter) injection pen and inject 15 unit subcutaneously three times a day for diabetes. The Novolog Flex Pen manufacturer's recommendations indicated the pen must be primed before each injection to ensure no air was present. To prime the insulin pen, turn the dosage knob to the 2 units indicator. With the pen pointing upward, push the knob in all of the way. Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated the insulin pen should have been primed. 3.1-48 (c)(2)

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure residents with dental concerns received the necessary services related to a follow up for a tooth extraction for 1 of 1 residents reviewed for dental services. (Resident M) Finding includes: During an interview on 12/13/22 at 2:44 p.m., Resident M indicated he had issues with his teeth. He had seen the dentist but had no follow up since then. The record for Resident M was reviewed on 12/19/22 at 10:15 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included but were not limited to, respiratory failure, tracheostomy, psychotic disorder, schizoaffective disorder, sleep apnea, high blood pressure, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 10/4/22 indicated the resident was cognitively intact. The resident had no issues with his teeth. There was no Care Plan for dental issues. A dental visit, dated 9/14/22, indicated a recommendation for the extraction of tooth #25. A dental visit, dated 10/5/22, indicated the resident had his teeth cleaned. The dentist's last visit in the facility was on 11/10/22 and the resident was not seen. There was no follow up for the tooth extraction recommendation. Interview with the Nurse Consultant on 12/20/22 at 2:20 p.m., indicated the resident had not seen the dentist after 10/5/22 and had not had the tooth extracted. 3.1-24(a)(3)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 32788 Based on observation, record review, and interview, the facility failed to ensure meals were served in a timely manner for 1 of 3 units. (West Unit) Findings include: 1. On 12/15/22 at 1:25 p.m., the first cart of lunch trays arrived on the [NAME] Unit and staff started passing them out. A list of meal times, provided by the facility as current, indicated on the [NAME] Unit, breakfast was to be served from 8:00 a.m. to 8:15 a.m., lunch was to be served from 12:45 p.m. to 1:00 p.m., and dinner was to be served from 6:15 p.m. to 6:30 p.m. 2. On 12/16/22 at 7:25 a.m., Dietary staff had brought down the beverage cart to the [NAME] Unit. At 8:02 a.m., the first cart of breakfast trays arrived on the unit. At 8:11 a.m., the second breakfast cart was delivered to the [NAME] Unit. At 8:14 a.m., two CNAs were passing trays on the middle hall and one CNA was preparing beverages. At 8:18 a.m., the third cart was delivered to the unit. No trays from the second cart had been passed. CNA 1 started passing trays from the third cart rather than the second cart. She was not in the area when the second cart was delivered. At 8:22 a.m., CNA 2 opened the second cart and CNA 1 told him, No, we are doing this one first. She was referring to the third cart. She said that cart had been there longer, even though she wasn't in the area when the second cart was delivered. At 8:28 a.m., the first tray was served from the second cart. At 8:36 a.m., staff stopped serving from the second cart. They had to call down to the kitchen for more glasses and milk. Staff continued to serve the second cart at 8:42 a.m. At 8:50 a.m., staff had to call down to the kitchen again for more coffee cups. A CNA returned with more cups at 9:02 a.m. The last tray on the cart was served at 9:10 a.m. 3. On 12/19/22 at 9:12 a.m., the first cart of breakfast trays arrived on the [NAME] Unit. The second cart of trays arrived at 9:15 a.m., the third cart arrived at 9:30 a.m., and the fourth cart arrived at 9:42 a.m. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A list of meal times, provided by the facility as current, indicated on the [NAME] Unit breakfast was to be served from 8:00 a.m.-8:15 a.m., lunch was to be served from 12:45 p.m. to 1:00 p.m., and dinner was to be served from 6:15 p.m. to 6:30 p.m. Interview with the Administrator on 12/19/22 at 3:00 p.m., indicated the dietary staff were compromised and they were having a problem with the meals being served on time. This Federal tag relates to Complaint IN00388811. 3.1-21(c)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45666 Based on observation and interview, the facility failed to serve and prepare food under sanitary conditions related to dirty food equipment and a dirty tray in the dry storage room for 1 of 1 kitchens observed. This had the potential to affect the 106 residents who received food from the kitchen. (The Main Kitchen) Findings include: During the Brief Kitchen Sanitation Tour on 12/13/22 at 9:43 a.m. with Cook 1, the following was observed: a. A dirty tray with garbage and food debris was sitting on the dry storage shelving unit b. Two ovens were dirty with built up food grime c. The stove top was dirty with built up food grime d. The meat slicer was dirty and had food debris on it Interview with the Dietary Food Manager on 12/19/22 at 9:10 a.m., indicated the food equipment was in need of cleaning. 3.1-21(i)(3)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45666 Based on interview and record review, the facility failed to ensure the resident's medical record was complete and accurate related to meal consumption logs for 1 of 6 residents reviewed for nutrition. (Resident 114) Finding includes: The record for Resident 114 was reviewed on 12/16/22 at 10:38 a.m. Diagnoses included, but were not limited to dementia, depression, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 12/4/22, indicated the resident was cognitively intact for daily decision making. A Care Plan, dated 10/27/22, indicated the resident had a potential for altered nutritional status/nutrition related problems related to history of dementia, high blood pressure, and depression. The CNA task sheet for Amount Eaten was reviewed for the last 30 days. There were no meal consumptions logged for the following days and meals: - 11/21/22: breakfast and lunch - 11/22/22: breakfast, lunch, and dinner - 11/23/22: breakfast, lunch, and dinner - 11/24/22: breakfast, lunch, and dinner - 11/30/22: breakfast and lunch - 12/1/22: breakfast and lunch - 12/2/22: breakfast - 12/5/22: breakfast and lunch - 12/6/22: dinner - 12/11/22: dinner - 12/13/22: breakfast and lunch - 12/17/22: dinner - 12/18/22: breakfast and lunch (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Nurse Consultant on 12/20/22 at 3:41 p.m., indicated she had no further information to provide. 3.1-50(a)(1)

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32788 Based on observation and interview, the facility failed to ensure the residents' environment as well as the kitchen area was clean and in good repair related to dirty floors, marred walls, and wash basins stored on the floor in 1 of 1 kitchen areas and on 1 of 3 units. (The Main Kitchen and [NAME] Unit) Findings include: 1. During the Environmental tour with the Director of Maintenance and the Director of Housekeeping on 12/21/22 at 11:10 a.m., the following was observed: West Unit: a. In room [ROOM NUMBER], the walls were marred in the entry way, behind bed one, and in the bathroom. There was rust on the pipes under the sink in the bathroom. Two residents resided in the room. b. In room [ROOM NUMBER], the wall behind bed two was marred and gouged. The base of the closet door was marred and gouged. Two residents resided in the room. c. In room [ROOM NUMBER], the wall behind bed one was marred. There was a brown dried substance on the floor near the bed. The bathroom walls were stained and there was a wash basin stored on the bathroom floor uncovered. Two residents resided in the room. d. In room [ROOM NUMBER], there were two wash basins stored on the bathroom floor uncovered. Two residents resided in the room. e. In room [ROOM NUMBER], the wall behind bed two was marred. There was a dried brown substance on the wall behind bed one and there was a wash basin stored on the bathroom floor uncovered. Two residents resided in the room. f. In room [ROOM NUMBER], there were two wash basins stored on the bathroom floor uncovered. Two residents resided in the room. g. In room [ROOM NUMBER], the walls were marred throughout the room. Two residents resided in the room. h. In room [ROOM NUMBER], there were two wash basins stored on the bathroom floor uncovered. Two residents resided in the room. Interview with the Maintenance and Housekeeping Directors at the time, indicated all of the above were in need of cleaning and/or repair. 2. During the Brief Kitchen Sanitation Tour on 12/13/22 at 9:43 a.m. with the Cook 1, the following was observed: (continued on next page)

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	12/21/2022

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. The floors throughout the kitchen were dirty with food debris and garbage. Interview with the Dietary Manager on 12/19/22 9:10 a.m., indicated the floors were in need of cleaning. 3.1-19(f)