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	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/26/23 Facility Number: 000123 Provider Number: 155218 AIM Number: 100266720 At this Emergency Preparedness survey, Great Lakes Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 134 and had a census of 121 at the time of this survey. Quality Review completed on 01/30/23	E 0000	The Plan of Correction is the center's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully requests a desk review for this plan of correction. Facility respectfully request paper compliance	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/26/23 Facility Number: 000123 Provider Number: 155218 AIM Number: 100266720 At this Life Safety Code survey, Great Lakes Healthcare Center was found not in compliance with Requirements for Participation in	K 0000	The Plan of Correction is the center's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully requests a desk	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason Eastlund	Executive Director	02/13/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo 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.

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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors; spaces open to the corridors and in resident sleeping rooms. Facility Rooms 7-13 are designed to support residents who are ventilator dependent. The factility is partially protected by a 125 kW generator and has full emergency generator protection with Life Support electrical components dedicated to rooms 7-13. The facility has an in-house dialysis unit used for only facility residents. The facility has the capacity of 134 and had a census of 121 at the time of the survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for a detached equipment storage building. Quality Review completed on 01/30/23		review for this plan of correction. Facility respectfully request paper compliance	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are			

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	used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies			

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	installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 The facility failed to ensure the delayed egress locking arrangements were installed in accordance with 7.2.1.6.1(3) in 3 of 12 exits. LSC 7.2.1.6.1(3) states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect staff and residents near the therapy and service hall. Findings include: Based on observations during tour of the facility with the Maintenance Director on 01/26/23 between 12:12 p.m. and 2:15 p.m., the exit door	K 0222	222 Facility had safe care come to facility and adjust the egress opening times to ensure that it was operable per state guidelines. Door currently opens in 15 seconds Facility audited all other egress doors to ensure compliance. No negative findings were noted. Maintenance dept were educated on K 222 expectations Maintenance dept will audit door openings weekly X 6 months to ensure compliance. All negative finding will be reviewed in monthly QAPI meeting	02/13/2023

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	near the therapy unit next to the ambulance entrance was provided with delayed egress locks and contain signage indicating the doors can be opened in 15 seconds by pushing on the door. When the exit doors were tested, it took 32 seconds to open instead of the posted 15 seconds. Based on interview at the time of observation, the Maintenance Director acknowledged the doors were equipped with a delayed egress with a sign stating the door will open in 15 seconds, but the doors took 32 seconds to open. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)			
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 3 ground fault circuit interrupter (GFCI) receptacles in the soiled utility room were properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect staff in the East Wing Findings include:	K 0511	511 Facility had GFCI electric receptacle replaced prior to date of compliance. Facility audited all GFCI receptacles were appropriately working. No negative findings were noted. Maintenance dept were educated on K 511. Maintenance dept will audit GFCI receptacles 1 X per month for 6	02/13/2023

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	Based on observation with the Maintenance Director on 01/26/23 between 12:12 p.m., when the GFCI electric receptacle in the utility room of East Wing near the nurses station was tested with a GFCI tester, the GFCI receptacle failed to trip and did not break the electrical circuit. Based on interview at the time of observation, the Maintenance Director agreed the GFCI electric receptacle did not properly work when tested. The finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		months to ensure compliance. All negative findings will be reviewed in monthly QAPI meeting.	