CENTERS FOF	R MEDICARE & MEDIC			OMB NO. 0938-0391			
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING	<u></u>	COMPLETED		
	155218		B. WING		10/26/2021		
			STREET	ADDRESS CITY STATE ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIE	155218 B. WING NVIDER OR SUPPLIER STREET ADDRESS, CITY, 2300 GREAT LAKES DYER, IN 46311 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVING PREFIX An Emergency Preparedness Survey was conducted by the Indiana Department of Health n accordance with 42 CFR 483.73. E 0000 Survey Date: 10/26/2021 For each of the survey, Great .acker Healtheare Center was found in compliance with Emergency Preparedness Requirements for Medicaid Participating Providers and Suppliers, 42 CFR 183.73 E 0000 The facility has 134 certified beds. At the time of the survey, the census was 86. K 0000 Quality Review completed on 11/01/21 K 0000 ALife Safety Code Recertification and State .icensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). K 0000 Survey Date: 10/26/2021 K 0000					
GREAT L	AKES HEALTHCA	ARE CENTER					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		(X5)		
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE		
E 0000							
Bldg							
J	An Emergency Pre	paredness Survey was	F 0000				
			E 0000				
		12 0110 105.75.					
	Survey Date: 10/2	6/2021					
	Facility Number:	000123					
	At this Emergency	Preparedness survey, Great					
	-						
	-						
	483.73	11 /					
	The facility has 13	4 certified beds. At the time					
	5,						
	Quality Review co	mpleted on 11/01/21					
		1					
K 0000							
Bldg. 01							
	A Life Safety Code	e Recertification and State	K 0000				
	Licensure Survey v	was conducted by the Indiana					
	Department of Hea	alth in accordance with 42					
	CFR 483.90(a).						
	Survey Date: 10/2	6/2021					
	Facility Number:	000123					
	Provider Number:	155218					
	AIM Number: 100	0266720					
	At this Life Safety	Code Survey, Great Lakes					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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FORM APPROVED

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			· /	(X3) DATE SURVEY COMPLETED 10/26/2021	
		155218				10/2		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
GREAT	LAKES HEALTHC	ARE CENTER			REAT LAKES DR IN 46311			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF	LD BE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		was found not in compliance						
	-	s for Participation in						
		d, 42 CFR Subpart 483.90(a),						
		Fire and the 2012 edition of the						
		ection Association (NFPA)						
	-	ode (LSC), Chapter 19,						
	-	are Occupancies and 410 IAC						
	16.2.							
		ility was determined to be of						
	Type V (111) cons	struction and was fully						
	sprinklered. The f	acility has a fire alarm system						
	with hard wired sr	noke detection in the corridors;						
	spaces open to the	corridors and in resident						
	sleeping rooms. Facility Rooms 7-13 are							
	designed to support	rt residents who are ventilator						
	dependent. The fa	ctility is partially protected by						
	a 125 kW generate	or and has full emergency						
	generator protection	on with Life Support electrical						
	components dedic	ated to rooms 7-13. The						
	facility has the cap	pacity of 134 and had a census						
	of 86 at the time o	f the survey.						
	All areas where th	e residents have customary						
	access were sprink	tlered. All areas providing						
	facility services w	ere sprinklered, except for a						
	detached equipme	nt storage building.						
	Quality Review co	ompleted on 11/01/21						
K 0341	NFPA 101							
SS=E	Fire Alarm Syste							
Bldg. 01	Fire Alarm Syste							
	-	em is installed with systems						
		approved for the purpose in						
		NFPA 70, National Electric						
		72, National Fire Alarm						
		effective warning of fire in						
		uilding. In areas not						
	continuously occ	upied, detection is installed						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155218 B. WING 10/26/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2300 GREAT LAKES DR GREAT LAKES HEALTHCARE CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility K 0341 K341 Fire Alarm System -10/27/2021 Installation failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72. National Fire Alarm What corrective action(s) will and Signaling Code, 2010 Edition. Section 14.5.1 states system equipment shall be be accomplished for those maintained in accordance with the manufacturer's residents found to have been published instructions. Section 17.4.4 states affected by the deficient initiating devices shall be supported practice – This hanging smoke independently of their attachment to the circuit detector was correct within one conductors. This deficient practice could affect hour of discovery. No resident up to 10 residents and staff in the south wing were harmed. when occupied. How other residents having the potential to be affected by the Based on observation on 10/26/2021 during a same deficient practice will be tour of the facility from 11:45 a.m. to 1:30 p.m. identified and what corrective with the Interim Administrator and Maintenance action(s) will be taken - All Director a smoke detector in the corridor by residents were affected by this resident room 13 was hanging from the ceiling. practice. Based on interview at the time of observation, the Maintenance Director stated the smoke What measures will be put into detector was hanging since the screw used to place and what systemic mount the smoke detector into the suspended changes will be made to ensure ceiling tile wasn't attached to anything. At the that the deficient practice does time of the survey, South Wing, where this not recur - The Maintenance smoke detector is located, was vacant and not Director was educated how to visually inspect for proper being used. installation of smoke detectors. This finding was reviewed with the Interim Administrator and Maintenance Director at the How the corrective action(s)

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exir conference.

Event ID:

AYEW21 Facility I

Facility ID: 000123

If continuation sheet P

will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance

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	R MEDICARE & MEDIONT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION		IB NO. 0938-039 1 E SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		· /	JILDING	<u>01</u>		LETED	
		B. WI	NG	<u>.</u>	10/26	6/2021	
NAME OF	PROVIDER OR SUPPLIE	P		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					REAT LAKES DR		
	LAKES HEALTHCA				IN 46311		(X5)
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CON		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					program will be put into pla The Maintenance Director wi inspect the smoke detector weekly. The Maintenance Director will review his audit the ED weekly for one month bi-weekly for two months and monthly for three months. The Maintenance Director will rep the findings to the monthly Q	ll , , he ort	
SS=F Bldg. 01	Fire Alarm - Out of Where required f services for more period, the author be notified, and the evacuated or an approvided for all parts shutdown until the been returned to 9.6.1.6	re alarm system is out of than 4 hours in a 24-hour rity having jurisdiction shall he building shall be approved fire watch shall be arties left unprotected by the e fire alarm system has service.					
	facility failed to pr policy for the prote procedures to be for alarm system has t four hours or more in accordance with deficient practice a visitors. Findings include:	view and interview, the ovide a complete written ection of residents indicating ollowed in the event the fire to be placed out of service for in a twenty four hour period LSC, Section 9.6.1.6. This ffects all residents, staff and	K 0.	346	K346 Fire Alarm System – (of service What corrective action(s) w be accomplished for those residents found to have bee affected by the deficient practice – This deficient prac- was correct at the time of discovery. No resident were harmed.	ill en tice	10/27/202
	Manual: Fire Wate 03/01/21 with the Interim Administra	f "Emergency Preparedness h" documentation dated ator and Maintenance Director w from 9:30 a.m. to 11:45			How other residents having potential to be affected by t same deficient practice will identified and what correcti action(s) will be taken – All	he be	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			. ,			(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		A. BUILDIN B. WING	A. BUILDING <u>01</u> B. WING			COMPLETED 10/26/2021	
	PROVIDER OR SUPPLIER		23	00 GR	DDRESS, CITY, STATE, ZIP CODE REAT LAKES DR N 46311		
X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID				(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	TAC	TAG CROSS-REFERENCED TO THE APPROPR		IATE	DATE	
	a.m. on 10/26/21, th			residents were affected by this			
	alarm system impai plan stated to contac			practice.			
	Health at 330-653-1			What measures will be put into			
	include an alternate			place and what systemic			
	Department of Heal			changes will be made to ensu			
	link at https://gatew			that the deficient practice doe	es		
	method or by the se IDOH Gateway is n			not recur – The Maintenance Director was educated to read			
	the Incident Report			new policies thoroughly to insu	Iro		
	incidents@isdh.in.g			he selects the proper policy an			
	time of record revie			procedure when changes are	iu iu		
	agreed fire watch do system impairment			made.			
	telephone number a			How the corrective action(s)			
	contact for the India			will be monitored to ensure th	he		
	the IDOH Gateway			deficient practice will not recu	ur,		
	listed above.				i.e., what quality assurance		
					program will be put into place	e –	
		viewed with the Interim			The Maintenance Director will		
		Maintenance Director during			review all changes with the	1	
	the exit conference.				Emergency Preparedness Mar with the ED. The ED will audit		
	3.1-19(b)				manual weekly for one month,	ule	
	5.1-19(0)				bi-weekly for two months and		
					monthly for three months. The	ED	
					will report the findings to the	D	
					monthly QAPI.		

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AYEW21 Facility ID: 000123

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