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	10/26/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/26/2021 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 134 certified beds. At the time of the survey, the census was 86. Quality Review completed on 11/01/21	E 0000		
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: 10/26/2021 Facility Number: 000123 Provider Number: 155218 AIM Number: 100266720 At this Life Safety Code Survey, Great Lakes	K 0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 01 B. WING	10/26/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Healthcare Center was found not in compliance with Requirements for Participation in 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 the capacity of 134 and had a census of 86 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 11/01/21			
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 01 B. WING	10/26/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition. Section 14.5.1 states system equipment shall be maintained in accordance with the manufacturer's published instructions. Section 17.4.4 states initiating devices shall be supported independently of their attachment to the circuit conductors. This deficient practice could affect up to 10 residents and staff in the south wing when occupied. Based on observation on 10/26/2021 during a tour of the facility from 11:45 a.m. to 1:30 p.m. with the Interim Administrator and Maintenance Director a smoke detector in the corridor by resident room 13 was hanging from the ceiling. Based on interview at the time of observation, the Maintenance Director stated the smoke detector was hanging since the screw used to mount the smoke detector into the suspended ceiling tile wasn't attached to anything. At the time of the survey, South Wing, where this smoke detector is located, was vacant and not being used. This finding was reviewed with the Interim Administrator and Maintenance Director at the exir conference.	K 0341	**K341 Fire Alarm System - Installation** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice –** This hanging smoke detector was correct within one hour of discovery. No resident were harmed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken –** All residents were affected by this practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur –** The Maintenance Director was educated how to visually inspect for proper installation of smoke detectors. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	10/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 01 B. WING	10/26/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			program will be put into place – The Maintenance Director will inspect the smoke detector weekly. The Maintenance Director will review his audit with the ED weekly for one month, bi-weekly for two months and monthly for three months. The Maintenance Director will report the findings to the monthly QAPI.	
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Emergency Preparedness Manual: Fire Watch" documentation dated 03/01/21 with the Interim Administrator and Maintenance Director during record review from 9:30 a.m. to 11:45	K 0346	**K346 Fire Alarm System – Out of service** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice –** This deficient practice was correct at the time of discovery. No resident were harmed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken –** All	10/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 01 B. WING	10/26/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a.m. on 10/26/21, the fire watch plan for fire alarm system impairment was inaccurate. The plan stated to contact the Ohio Department of Health at 330-653-1300. The plan failed to include an alternate contact for Indiana Department of Health (IDOH) using the Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview at the time of record review, the Maintenance Director agreed fire watch documentation for fire alarm system impairment had the wrong State and telephone number and did not state the alternate contact for the Indiana Department of Health via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Interim Administrator and Maintenance Director during the exit conference. 3.1-19(b)		residents were affected by this practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur –** The Maintenance Director was educated to read new policies thoroughly to insure he selects the proper policy and procedure when changes are made. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place –** The Maintenance Director will review all changes with the Emergency Preparedness Manual with the ED. The ED will audit the manual weekly for one month, bi-weekly for two months and monthly for three months. The ED will report the findings to the monthly QAPI.	