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	02/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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: 02/05/24 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 120 at the time of this survey. Quality Review completed on 02/07/24	E 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. Facility respectfully requests 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: 02/05/24 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	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. Facility respectfully requests paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason Eastlund	Executive Director	02/16/2024

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 were originally used for residents dependant on life support, however the facility does not currently accept those residents. 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 120 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 02/07/24			
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities			

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	having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to follow and provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures complying with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Maintenance Director on 02/05/24 between 09:03 a.m. and 10:59 a.m., two fire watch policies were provided during the survey. One fire watch policy indicated that the Indiana Department of Health should be notified via the IDOH Gateway link at	K 0354	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** K 354 ED and maintenance director placed new policy in Emergency Preparedness Manual ED conducted a 2 week look back of fire system operations and no issues identified ED and maintenance department educated on Fire Watch policy and procedure ED/designee will audit all fire watch incidents as they occur for the next 6 months.	02/16/2024

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	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. The second, and most current, fire watch policy did not address that the Indiana Department of Health should be notified via the aforementioned methods. Furthermore, the facility had a recent fire sprinkler system outage due to a broken sprinkler pipe. The outage happened on 01/19/24 that lasted from approximately 4 a.m. and went until 7 p.m. on the same day. A fire watch was conducted; however the Indiana Department of Health was not notified of the fire watch and sprinkler outage as regulated by NFPA 25. Based on interview at the time of record review, the Maintenance Director did not know if the event had been reported but did state that they had a sprinkler outage a few times this current year, but unsure if it was reported or not. At exit conference, the Executive Director was interviewed and confirmed that the sprinkler outage on 01/19/24 and did not report it to IDOH because the most current state regulations did not indicate that the sprinkler outage did not address having to report the incident of an outage of the sprinkler and fire alarm system. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous			

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	Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage/transfer locations had proper separation in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1(1) states, (transfilling shall occur in) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. This deficient practice could affect approximately 30 residents and staff in East Hall Findings include: During record review between 09:03 a.m. and 10:59 a.m. with the Maintenance Director on 02/05/24, a loud unusual noise from the east hall was observed from the east dining lounge where the surveyor and Maintenance Director was located. Upon discovery, transfilling was in progress within the oxygen storage/transfilling room in the East hall. However, the employee conducting the transfilling had the door propped open with their foot. After transfilling had ended, the employee was asked what the proper procedure was when transfilling. The employee responded by applying the proper PPE and then proceed to transfill. During further investigation, the employee was asked if it is procedure to prop the door open to which the employee stated no. She confirmed that	K 0927	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** K 927 ED educated staff member on policy and procedure for filling O2 ED looked at all O2 rooms to ensure nothing was being used to prop the door open ED/designee educated all nursing staff on policy and procedures for filling O2 ED/designee will monitor 5 O2 fill ups per week for 6 months. ED/designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. The IDT will determine if	02/16/2024

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	the door was not supposed to be propped open while transfilling was in progress. The Maintenance Director, during observation, also confirmed that the door was propped open while transfilling was in progress. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		the audits are necessary to continue after 6 months with 100% compliance achieved.	