STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING _____ B. WING _____	**10/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented to properly prevent and/or contain Covid-19 related to isolation gowns hanging on the doors of residents rooms during random observations on 2 of 3 wings. (East & West wings) Findings include: 1. On 10/19/20 at 9:20 a.m. Two residents were observed in room [ROOM NUMBER] on the East wing. The East wing was designated as a Green Unit indicating the unit had no active Covid 19 or isolation residents at this time. A white plastic isolation gown was hanging on the outside of the room door. No isolation bins were in the room or by it. Both residents were in bed and the room door was open. No isolation notices were posted on the door. No staff were present in the room at this time. When interviewed on 10/19/20 at 9:40 a.m., LPN 1 indicated there were no Covid positive residents on the unit. She did not know why the isolation gown was hanging on the outside of the room door. The LPN indicated the night shift staff did not inform her of either of the 2 residents in that room being in isolation or having any Covid symptoms. When interviewed on 10/19/20 at 10:00 a.m., the facility Administrator indicated the above 2 residents were moved to the Green unit (Covid free unit) when other residents recently tested positive for Covid 19. Neither resident was currently in isolation. All staff should be aware of which residents were in isolation and dispose of PPE (Personal Protective Equipment) appropriately. 2. On 10/19/30 at 1:20 p.m., the room door for room [ROOM NUMBER] was closed. Two isolation gowns were hanging on the outside of the door. The residents resided on the West wing Yellow Zone unit. The Yellow Zone was being utilized for residents potentially exposed to Covid 19. LPN 2 indicated residents on the unit were to have Droplet precautions in place. The LPN was not aware of why the gowns were on the outside of the door or if the gowns had been used. When interviewed on 10/19/20, Nurse 2 indicated she was unsure why the isolation gowns were hanging on the door. When interviewed on 10/19/20 at 9:15 a.m., the facility Administrator indicated all staff members were to be aware of the isolation procedures and the use, storage and disposal of PPE on each unit. The gowns should not have been on the outside of the doors. The facility Covid-19 PPE policy did not address storage or disposal after use. The directives for using PPE found on the cdc.gov website indicated, Remove gown . Dispose in trash receptacle 3.1-18(a)

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