STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING -- B. WING	06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(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 Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/20/23 Facility Number: 000076 Provider Number: 155156 AIM Number: 100271060 At this Emergency Preparedness survey, Aperion Care Arbors Michigan City was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR Subpart 483.73. The facility is certified for 180 beds. The facility maintains 147 dual Medicare and Medicaid beds and 33 Medicare only beds. At the time of the survey, the census was 132. Quality Review completed on 06/26/23	E 0000	Preparation and/or 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. The 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 these alleged deficient practices.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Todd Smith	Executive Director	07/06/2023

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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	§494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.			

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	155156	A. BUILDING -- B. WING	06/20/2023

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	. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 06/20/23 between 09:30 a.m. and 11:55 a.m., the EPP provided had a date of April 2021 on a document titled "Annual Review of Policy Procedure" no other date could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the facility EPP binders and policies have been in the process of revision and agreed that the EPP provided by the Maintenance Director had a revision date more than a year old.. This finding was reviewed with the Maintenance Director and Administrator during the exit conference.	E 0004	Tag number: E004 – Develop EP Plan, Review and Update Annually I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The Administrator and Maintenance Director reviewed and updated the EPP. The review was documented by 7-17-2023**. II.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 have the potential to be affected by the alleged deficient practice. The Administrator and Maintenance Director reviewed and updated the EPP. The review was documented by 7-17-2023**. III.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate Maintenance Director on the need for annual review and update of the EPP by 7-17-2023.**	07/17/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			IV.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 in place. **Administrator/designee will conduct an annual audit for the review and updating of the EPP. The results of these audits will be reviewed in Quality Assurance Meeting annually. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 7/17/2023	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph			

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	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies			

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	and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 06/20/23 between 09:30 a.m. and 11:55 a.m., the EPP review sheet titled "Annual Review of Policy Procedure and Guidelines" had a date of April 2021, no other date could be found to show the EPP's Policies and Procedures were reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the EPP policies and binders within the facility have been in the process of being updated. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0013	Tag number: E013 – Development of EP Policies and Procedures I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The Administrator and Maintenance Director reviewed and updated the EP Policies and Procedures. The review was documented by 7-17-2023**. II.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 have the potential to be affected by the alleged deficient practice. The Administrator and Maintenance Director reviewed and updated**	07/17/2023

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			the EP Policies and Procedures. The review was documented by 7-17-2023. III.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate Maintenance Director on the need for annual review and update of the EP Policies and Procedures by 7-17-2023.** IV.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 in place. **Administrator/designee will conduct an annual audit to for the review and updating of the EP Policies and Procedures. The results of these audits will be reviewed in Quality Assurance Meeting annually. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 7/17/2023	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c),			

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	491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 06/20/23 between 09:30 a.m. and 11:55 a.m., the EPP had a date of April 2021 on a document titled "Annual Review of Policy Procedure and Guidelines." No other date could be found to show the EPP's Communication Plan was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated that the binders and policies for the EPP were still in the process of being updated. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0029	Tag number: E029 – Development of Communication Plan I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The Administrator and Maintenance Director reviewed and updated the EPP Communication Plan. The review was documented by 7-17-2023**. II.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 have the potential to be affected by the alleged deficient practice. The Administrator and Maintenance Director reviewed and updated the EPP Communication Plan.**	07/17/2023

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			The review was documented by 7-17-2023. III.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate Maintenance Director on the need for annual review and update of the EPP Communication Plan by 7-17-2023.** IV.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 in place. **Administrator/designee will conduct an annual audit to for the review and updating of the EPP Communication Plan. The results of these audits will be reviewed in Quality Assurance Meeting annually. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 7/17/2023	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d),			

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	485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least			

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	annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed reviewed and updated the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Director of	E 0036	**Tag number: E036 – EP Training and Testing** I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The Administrator and Maintenance Director reviewed and updated the EPP Training and Testing**	07/17/2023

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	Nursing (DON) and the Maintenance Director on 06/20/23 between 09:30 a.m. and 11:55 a.m., the EPP had a date of April 2021 on a document titled "Annual Review of Policy Procedure and Guidelines." No other date could be found to show the EPP's Training and Testing Plan was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated that the binders and policies for the EPP were in the process of being updated. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		**Plan. The review was documented by 7-17-2023**. II.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 have the potential to be affected by the alleged deficient practice. The Administrator and Maintenance Director reviewed and updated the EPP Training and Testing Plan. The review was documented by 7-17-2023**. III.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate Maintenance Director on the need for annual review and update of the EPP Training and Testing Plan by 7-17-2023.** IV.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 in place. **Administrator/designee will conduct an annual audit to for the review and updating of the EPP Training and Testing Plan. The results of these**	

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			audits will be reviewed in Quality Assurance Meeting annually. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 7/17/2023	
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: 06/20/23 Facility Number: 000076 Provider Number: 155156 AIM Number: 100271060 At this Life Safety Code survey, Aperion Care Arbors Michigan City 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 smoke detection in the corridors, spaces open to the corridors, and in all resident sleeping rooms. The majority of the building is partially	K 0000	Preparation and/or 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. The 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 these alleged deficient practices.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 01 B. WING	06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

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	protected by a 45-kW natural gas-powered emergency generator. Resident rooms 301-312, which contain a non-operational ventilator unit, are fully protected by a 40-kW natural gas-powered generator. The facility is certified for 180 beds. The facility maintains 147 dual Medicare and Medicaid beds and 33 Medicare only beds. At the time of the survey, the census was 132. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered Quality Review completed on 06/26/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			
	Based on observation and interview, the facility failed to ensure 2 of 8 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect approximately 30 staff and residents Findings include: Based on an observation during a tour of the facility with the Maintenance Director 06/20/23 between 11:58 a.m. and 2:44 p.m., the exit corridor near the time clock area next to 200 hall contained storage taking up part of the corridor with items	K 0211	Tag number: K211 – Means of Egress – General I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The Maintenance Director removed all obstructions in the exit corridor near the time clock area next to 200 Hall and the exit corridor next to resident room 224.**	07/17/2023

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	that included a vacuum, trash barrels, boxes, a hand cart, and a step stool. Furthermore, the exit corridor next to resident room 224 had storage taking up half of the corridor that contained three pallets of construction material and boxes of furniture. Based on an interview at the time of observations, the Maintenance Director agreed there was a lot of storage in the two exit corridors and stated that the items will be removed. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		II.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 have the potential to be affected by the alleged deficient practice. The Maintenance Director performed a 100% audit of all exit corridors and removed all obstructions found by 7-17-2023** III.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate Maintenance Director on the need for all means of egress to be continuously maintained free of all obstructions or impediments to full instant use in case of fire or other emergency by 7-17-2023.** IV.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 in place. **The Maintenance Director/designee will audit all egress areas to ensure free of obstructions as follows: 5X/week for 8 weeks, then 3X/week weekly. The**	

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			results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until as average of 90% compliance or greater is achieved X3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 7/17/2023	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A			

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	a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 1 storage rooms on the 300 hall with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect approximately 30 residents and staff. Findings include: Based on observation during a tour of the facility with Maintenance Director on 06/20/23 between 11:58 a.m. and 2:44 p.m., the 300 hall office storage room contained over 30 boxes of supplies and was greater than 50 square feet making this a hazardous area. The storage room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Director agreed the storage room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0321	Tag number: K321 – Hazardous Areas – Enclosure I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The Maintenance Director installed a self-closing device to the 300 Hall Office Storage Room by 7-17-2023.** II.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 have the potential to be affected by the alleged deficient practice. The Maintenance Director performed a 100% audit of all storage rooms to ensure all rooms with large amounts of combustible storage and great than 50 square feet to be protected as a hazardous area**	07/17/2023

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			have self-closing/automatic devices by 7-17-2023 III.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate Maintenance Director on the need of all storage rooms with large amounts of combustible storage and great than 50 square feet to be protected as a hazardous area have self-closing/automatic devices by 7-17-2023.** IV.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 in place. **The Maintenance Director/designee will audit all storage areas to ensure self-closing/automatic devices are present per regulation as follows: 5X/week for 8 weeks, then 3X/week weekly. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until as average of 90% compliance or greater is achieved X3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the**	

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			plan of correction as indicated. Date of compliance: 7/17/2023	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to maintain 2 of 5 backflow devices on the automatic sprinkler system in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance	K 0353	Tag number: K353 – Sprinkler System – Maintenance and Testing I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The facility had the 2 failed backflows – Riser room and Boiler Room on 400 Unit - on the automatic**	07/17/2023

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	required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review of two documents titled "Sprinkler: Backflow Prevention Test - Equipment" documentation dated 05/25/23 with Maintenance Director on 06/20/23 between 09:30 a.m. and 11:55 a.m., the two backflow inspection reports had a backflow device located in the "Riser Room" and one in the "Boiler Room 400" both had failed their annual inspection. Based on interview at the time of record review, the Maintenance Director confirmed that the two backflow devices had failed and have not been repaired since the last inspection. The Maintenance Director was able to provide a Proposal for repair and stated they were waiting for the repair company to schedule a time to fix the deficiencies. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 2 of 2 sprinkler systems in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and		**sprinkler system replaced/fixed by 7-17-2023. All monthly inspections of the wet/dry sprinkler system's gauges and valves are current as of 7-17-2023.** II.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 have the potential to be affected by the alleged deficient practice. The Maintenance Director performed a 100% audit of all backflow devices on the automatic sprinkler system to ensure proper functioning by 7-17-2023. All monthly inspections of the wet/dry sprinkler system's gauges and valves are current as of 7-17-2023.** III.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate Maintenance Director on the need to ensure all backflow devices on the automatic sprinkler system are functioning properly by 7-10-2023. In addition, the Administrator will re-educate the Maintenance Director on**	

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	Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 06/20/23 between 09:30 a.m. and 11:55 a.m., there was no monthly inspection of the wet and dry pipe sprinkler system's gauges and valves for the months of June 2022 to September 18, 2022. During an interview at the time of record review, the Maintenance Director stated the only documentation he had were inspection documentation he has done since the beginning of September to now. The Maintenance Director further stated that he started in September of 2022 and could not find documentation of monthly and weekly gauge and valve inspections before September 18, 2022. Findings were discussed with the Maintenance Director and Administrator 3.1-19(b)		**the necessity of ensuring all monthly inspections of the wet/dry sprinkler system's gauges and valves are completed and the system is properly functioning by 7-17-2023.** IV.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 in place. **The Maintenance Director/designee will audit all backflow devices and wet/dry sprinkler system's gauges and valves as follows: 5X/week for 8 weeks, then 3X/week weekly. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until as average of 90% compliance or greater is achieved X3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 7/17/2023	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other			

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	than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility	K 0363	Tag number: K363 – Corridor –	07/17/2023

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	failed to ensure 1 of 25 resident room corridor doors on the 400 hall were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 2 residents. Findings include: Based on observation with the Maintenance Director on 09/20/23 between 11:58 a.m. and 2:44 p.m., the corridor door to resident room 431 did not latch into the frame when tested twice. Based on interview at the time of observation, the Maintenance Director acknowledged and agreed that the door would not latch into the frame and would need to be fixed. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		Doors I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The corridor door to resident room 431 was repaired and closes properly as to latching into the frame of the door.** II.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 have the potential to be affected by the alleged deficient practice. The Maintenance Director performed a 100% audit of all resident room corridor doors to ensure proper functioning as to latching into the frame of the door by 7-17-2023.** III.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate Maintenance Director on the need to ensure resident room corridor doors properly function as to latching into the frame of the door by 7-17-2023.**	

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			IV.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 in place. **The Maintenance Director/designee will audit all resident room corridor doors to ensure proper functioning as to latching into the frame of the door as follows: 5X/week for 8 weeks, then 3X/week weekly. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until as average of 90% compliance or greater is achieved X3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 7/17/2023	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established			

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	routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Maintenance Director on 06/20/23 between 09:30 a.m. and 11:55 a.m., the following shifts were missing documentation of a completed fire drill: a) A first shift fire drill in the third quarter of 2022. b) A third shift fire drill in the third quarter of 2022. Based on interview at the time of record review, the Maintenance Director stated the drills could have been completed, but the drills would have been conducted before he was employed at the facility. The Maintenance Director also acknowledged that no other documentation was able to be located to confirm if the drills had been conducted. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)	K 0712	Tag number: K712 – Fire Drills I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The facility Maintenance Director has performed fire drills according to the regulation of quarterly on each shift under varied conditions in 2023.** II.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 have the potential to be affected by the alleged deficient practice. The Maintenance Director has performed fire drill according to the regulation of quarterly on each shift under varied conditions in 2023.** III.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate**	07/17/2023

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	155156	A. BUILDING 01 B. WING	06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(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
			Maintenance Director on the need to ensure fire drills are performed quarterly on each shift and under varied conditions. IV.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 in place. **The Maintenance Director/designee will audit all fire drills to ensure they are performed quarterly on each shift and under varied conditions as follows: Monthly for 6 months. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until as average of 90% compliance or greater is achieved X3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 7/17/2023	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions:			

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	(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect approximately 10 residents in the courtyard. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 06/20/23 between 11:58 a.m. and 2:44 p.m., in the courtyard resident smoking area there were over 30 cigarette butts disposed on the ground in and around the	K 0741	Tag number: K741 – Smoking Regulations I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **All cigarette butts in the courtyard smoking area have been removed.** II.How other residents having the potential to be affected by the	07/17/2023

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	smoking area. Based on interview at the time of observations, the Maintenance Director agree there were cigarette butts on the ground in the aforementioned location and states that cleaning of cigarette butts are conducted during the week. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director performed a 100% audit of the facility property to ensure all disposal of cigarette butts in a metal or non-combustible container with a self-closing cover device by 7-17-2023.** III.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate Maintenance Director on the need to ensure disposal of cigarette butts in a metal or non-combustible container with a self-closing cover device by 7-17-2023.** IV.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 in place. **The Maintenance Director/designee will audit 100% of the facility property to ensure all disposal of cigarette butts in a metal or non-combustible container with a self-closing cover as follows: 5 X week for 8 weeks, then 3 X**	

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			week weekly. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until as average of 90% compliance or greater is achieved X3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 7/17/2023	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon			

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	completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 12 staff and residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 06/20/23 between 11:58 a.m. and 2:44 p.m., an air conditioner unit was plugged into and supplied by an extension cord in the med room of the 400 unit nurses station. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and stated there had been issues with temperature control in the room and installed the unit to fix the issue. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring.	K 0920	Tag number: K920 – Electrical – Power Cords and Extension Cords I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The AC in the medication room on the 400 unit nurses station has been plugged into a regulation fixed wired wall outlet; the mini fridge in the Administrator's office is not plugged into a regulation fix wired wall outlet; the microwave and mini fridge in the housekeeping office has been plugged into a regulation fix wired wall outlet; the microwave and mini fridge in the DON office have been plugged into a regulation fixed wired wall outlet.** II.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 have the potential to be affected by the alleged deficient practice. The Maintenance Director performed a 100% audit of the**	07/17/2023

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	This deficient practice could affect approximately 8 staff and an unknown number of residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 06/20/23 between 11:58 a.m. and 2:44 p.m., the following deficiencies were noted: a) A mini fridge was plugged into and powered by a powerstrip located in the Executive Director's office. The powerstrip was removed upon observation by the Maintenance Director. b) A microwave and minifridge were plugged into and powered by a powerstrip located in the housekeeping office in 300 hall. Furthermore, the power strip was dangling and putting unnecessary stress on the power cord. The powerstrip was removed upon observation by the Maintenance Director. c) A microwave and minifridge was plugged into and supplied power by a powerstrip. Furthermore, the power strip was dangling and putting unnecessary stress on the power cord located in the DON office in 400 unit. Based on interview at the time of observation, the Maintenance Director acknowledged power strips were supplying power to high power draw equipment and some were dangling from the power cord. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		**facility property to ensure flexible cords and cables are not being used as a substitute for fixed wiring by 7-17-2023.** III.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate Maintenance Director on the need to ensure flexible cords and cables are not being used as a substitute for fixed wiring by 7-17-2023.** IV.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 in place. **The Maintenance Director/designee will audit the entire facility as follows: 3 X week for 8 weeks, then weekly. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until as average of 90% compliance or greater is achieved X3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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