PRINTED:	06/20/2022
FORM AP	PROVED
OMB NO.	0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

		IDENTIFICATION NUMBER: 155156	A. BUILDING B. WING		COMPLETED 06/02/2022
	PROVIDER OR SUPPLIER		1101 E	ADDRESS, CITY, STATE, ZIP CODE COOLSPRING AVE GAN CITY, IN 46360	
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA"	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
E 0000					
Bldg	State Licensure Sur	paredness Recertification and vey was conducted by the of Health in accordance with	E 0000		
	Survey Date: 06/02	/22			
	Facility Number: 00 Provider Number: 1 AIM Number: 1002	155156			
	Care Arbors at Mich compliance with En Requirements for M	Preparedness survey, Aperion nigan City was found in nergency Preparedness fedicare and Medicaid ters and Suppliers, 42 CFR			
	maintains 147 dual and 33 Medicare on survey, the census w				
	Quality Review con	npleted on 06/06/22			
K 0000					
Bldg. 01	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 /22	K 0000		
	Facility Number: 00 Provider Number: 1				

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

TITLE

(X6) DATE

Any definencystatement 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.

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI B. WIN	LDING	01	COMPLETED 06/02/2022	
		155156	D. WIN				2/2022
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE COOLSPRING AVE		
APERIO	N CARE ARBORS	MICHIGAN CITY			GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTI	ION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	F	REFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO) BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	AIM Number: 10	0271060					
	At this Life Safety	Code survey, Aperion Care					
		n City was found not in					
	compliance with F	Requirements for Participation					
	in Medicare/Medi	caid, 42 CFR Subpart					
	483.90(a), Life Sa	fety from Fire, and the 2012					
	edition of the Nati	onal Fire Protection					
	Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care	A) 101, Life Safety Code					
	Occupancies and 4	10 IAC 16.2.					
	This one-story fac	ility was determined to be of					
	Type V (111) cons	struction and was fully					
	sprinklered. The fa	acility has a fire alarm system					
		ion in the corridors, spaces					
	-	ors, and in all resident sleeping					
	-	ty of the building is partially					
		kW natural gas-powered					
		tor. Resident rooms 301-312,					
		on-operational ventilator unit,					
		by a 40-kW natural					
	° , °	rator. The facility is certified					
		facility maintains 147 dual					
		licaid beds and 33 Medicare ime of the survey, the census					
	was 115.	ine of the survey, the census					
	All areas where th	e residents have customary					
		lered. All areas providing					
	facility services w						
	Quality Review co	ompleted on 06/06/22					
0211	NFPA 101						
SS=E	Means of Egress						
Bldg. 01	Means of Egress						
		vays, corridors, exit					
	-	ocations, and accesses are					
	in accordance wi	th Chapter 7, and the					

TERS FO	R MEDICARE & MEDI	CAID SERVICES				OM	IB NO. 0938-0391
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u>			COMPLETED	
		155156	B. WIN	G		06/02	/2022
NAME OF	PROVIDER OR SUPPLIE	ŪR			DDRESS, CITY, STATE, ZIP CODE	•	
	N CARE ARBORS				AN CITY, IN 46360		
X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	free of all obstruct emergency, unle through 18/19.2. 18.2.1, 19.2.1, 7. Based on observat		K 02	11	K-221 Means to Egress		06/25/2022
	free from obstruction the facility. LSC 1 into the required w	ions in 1 of 8 corridors within 9.2.3.4(4) states, projections vidth shall be permitted for			The facility requests paper compliance for this citation.		
	wheeled equipmer	nt, provided that all of the			This Plan of Correction is the	ie	
	following condition	ns are met:			center's credible allegation	of	
	(a) The wheeled ea	quipment does not reduce the			compliance.		
	clear unobstructed	corridor width to less than 60					
	in. (1525 mm.)				Preparation and/or execution	n of	
		e occupancy fire safety plan			this plan of correction does	not	
	and training progra	am address the relocation of			constitute admission or		
	the wheeled equip	ment during a fire or similar			agreement by the provider of	of	
	emergency.				the truth of the facts alleged	lor	
		quipment is limited to the			conclusions set forth in the		
	following:				statement of deficiencies.		
	i. Equipment in us				plan of correction is prepar		
	-	ency equipment not in use			and/or executed solely beca		
		transport equipment			it is required by the provision	ons	
	This deficient prac				of federal and state law.		
		residents, 4 staff and 2					
	visitors.				Immediate actions tak	-	
					for those residents identifie	d:	
	Findings include:				The DOM ensured All		
					PVC carts were removed fro	m	
		ions made with the Director of			hallways including		
		M) on 06/02/22 during a tour			The carts outside roo	ms	
	-	n 12:30 p.m. to 2:31 p.m. the			#109 #125		
	following was not				The isolation cart out		
		ted cart containing 25			of #214 was replaced with a		
	-	towels, 5 bedsheets, 5 patient kets was stored in the corridor			wheeled isolation cart. Pallet was removed fr		

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currently in use.

outside resident room #109 and was not

2) a PCV constructed cart containing 20

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the hallway near room #222

from the 300 room area.

PCV cart was removed

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155156 B. WING 06/02/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 E COOLSPRING AVE APERION CARE ARBORS MICHIGAN CITY MICHIGAN CITY, IN 46360 (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 DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) washrags, 5 bath towels, 4 bedsheets, 8 patient 2) How the facility identified gowns, and 5 blankets was stored in the corridor other residents: outside resident room #125 and was not Visitors. staff and residents currently in use. 3) a small 3 drawer cart containing that reside at the community miscellaneous contact isolation items was stored have the potential to be in the corridor immediately outside resident affected by the alleged deficient room #214 and was not on wheels. practice. 4) an empty delivery pallet was sitting on the 3) Measures put into place/ floor in the corridor immediately outside resident room #222 and was not in use or System changes: attended. 5) a PCV constructed cart containing 15 The Maintenance washrags, 6 bath towels, 4 bedsheets, 3 patient **Director or Designee in** gowns, and 2 packages of adult diapers was serviced the staff on the means stored in the corridor outside resident room to egress and not having carts #306 and was not currently in use. and non-emergency equipment Based on interview with the DOM at the time of in the hallway. An audit will be conducted 5 days a week to each observation, he acknowledged the items in the corridor and were not supposed to be stored ensure that the alleged there or left unattended and stated that he would deficient practice does not hold an in-service for staff in hopes of occur. The Maintenance remedying this issue. During the exit conference Director is responsible for with the facility Executive Director and the DOM at 2:45 p.m., no additional information or compliance. evidence could be provided contrary to this deficient finding. 4. How the corrective actions will be monitored: 3.1-19(b) The Executive Director will review the Preventative **Maintenance Worksheets** monthly. The results of these audits will be reviewed in **Quality Assurance Meeting** monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify

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AND PLAN	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155156	(X2) MULTIPLE CONSTRUCTION A. BUILDING D1 B. WING			СОМ	(X3) DATE SURVEY COMPLETED 06/02/2022	
	PROVIDER OR SUPPLIE		•	1101 E	ADDRESS, CITY, STATE, ZIP CC COOLSPRING AVE GAN CITY, IN 46360	DDE		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	ECTION DULD BE	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	DATE	
					any trends or patterns make recommendation revise the plan of corre indicated.	ns to		
K 0222 SS=E Bldg. 01	not be equipped requires the use egress side unles special locking al CLINICAL NEED LOCKING Where special lo clinical security n used, only one lo permitted on eac be made for the n by: remote contro locks or keys car other such reliab staff at all times. 18.2.2.2.5.1, 18.2 19.2.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special lo safety needs of the the Clinical or Se are being met. In electrical locks the release upon loss building is protect	S OR SECURITY THREAT cking arrangements for the eeds of the patient are cking device shall be h door and provisions shall rapid removal of occupants of of locks; keying of all ried by staff at all times; or le means available to the 2.2.2.6, 19.2.2.2.5.1, S LOCKING			5) Date of compliance	: 6/25/22		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155156			01		MPLETED 5/02/2022
		100100					,02,2022
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	E	
APERIO	N CARE ARBORS	MICHIGAN CITY			ECOOLSPRING AVE GAN CITY, IN 46360		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES ID		,		(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU		COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPF DEFICIENCY)	ROPRIATE	DATE
		cation within the locked					
		the sprinkler and detection					
		nged to unlock the doors					
	upon activation.						
		2.2.2.5.2, TIA 12-4					
	DELAYED-EGRE						
	ARRANGEMENT						
		delayed-egress locking					
		in accordance with					
	-	e permitted on door					
		ng low and ordinary hazard					
		ngs protected throughout by					
		pervised automatic fire					
		or an approved, supervised					
	automatic sprinkl						
	18.2.2.2.4, 19.2.2	-					
		ROLLED EGRESS					
	LOCKING ARRA	NGEMENTS					
	Access-Controlle	d Egress Door assemblies					
		dance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2	2.2.4					
	ELEVATOR LOB	BY EXIT ACCESS					
	LOCKING ARRA	NGEMENTS					
	Elevator lobby ex	tit access door locking in					
	accordance with	7.2.1.6.3 shall be permitted					
	on door assembl	ies in buildings protected					
		approved, supervised					
	automatic fire de	tection system and an					
	approved, superv	vised automatic sprinkler					
	system.						
	18.2.2.2.4, 19.2.2						
		ion and interview, the facility	K 0	222	K-222		06/25/202
		e means of egress through 3 of					
		y accessible for residents			The facility requests paper		
		liagnosis requiring specialized			compliance for this citat	ion.	
		Doors within a required					
		all not be equipped with a			This Plan of Correction		
		equires the use of a tool or			center's credible allegat	ion of	
	L key from the egres	s side unless otherwise	1		compliance.		

STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 B. WING 06/02/2022 155156 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 E COOLSPRING AVE APERION CARE ARBORS MICHIGAN CITY MICHIGAN CITY, IN 46360 (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) permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance Preparation and/or execution of with 19.2.2.2.5.2. This deficient practice could this plan of correction does not affect over 48 residents, 8 staff and 4 visitors if constitute admission or agreement by the provider of needing to exit the facility. the truth of the facts alleged or Findings include: conclusions set forth in the statement of deficiencies. The Based on observations made with the Director of plan of correction is prepared Maintenance (DOM) on 06/02/22 during a tour and/or executed solely because of the facility from 12:30 p.m. to 2:31 p.m. the it is required by the provisions of federal and state law. following exit doors were marked as a facility exit, were magnetically locked and could be opened by entering a four-digit code but the code Immediate actions taken for those residents identified: was not posted at the exit: 1) the entry / exit leading to the facility All exits were labeled designated smoking area. visibly with a four digit code 2) the entry / exit to the employee parking lot. including but not limited to 3) the entry / exit leading to the Physical Therapy The entry/exit leading to the facility designated smoking room. 4) the entry / exit outside the Physical Therapy area The entry/exit to the area. employee parking lot 5) the 400 Hall exit near resident rooms #416 and #417. The entry exit leading to 6) the 400 Hall exit nearest to the Social the therapy room Services office. The entry/exit outside the therapy room Based on interview at the time of the The 400 hall exit near observations, the DOM stated the resident rooms #416 and #417 aforementioned facility exits were indeed The 400 hall exit nearest marked as exits and could be opened by entering the Social Services office a four-digit code, but the code was not posted 2) How the facility identified adding that some of the door keypads were not other residents: functioning properly and that his Vendor was scheduled to come repair or replace them in the Visitors, staff and residents near future. During the exit conference with the that reside at the community facility Executive Director and the DOM at 2:45 have the potential to be affected by the alleged deficient p.m., no additional information or evidence could be provided contrary to this deficient finding. practice.

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			(X3) DATE SURVEY COMPLETED	
		155156				06/02	2/2022
	ROVIDER OR SUPPLIE			1101 E	ADDRESS, CITY, STATE, ZIP CODE COOLSPRING AVE		
APERIO	N CARE ARBORS	MICHIGAN CITY		MICHIG	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION				(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	3.1-19(b)				3) Measures put into place/		
					System changes:		
					 The Maintenance Director or Designee in serviced the staff on ensurin that door codes are visible at all times to staff, residents at visitors An audit will be conducted 5 days a week to ensure that the alleged deficient practice does not occur. The Maintenance Director is responsible for compliance. How the corrective action will be monitored: 	t nd	
					The Executive Director will review the Preventative Maintenance Worksheets monthly.		
					The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or unti 100% compliance is achieved The QA Committee will ident any trends or patterns and make recommendations to revise the plan of correction indicated.	d. ify	
(0331 SS=E	NFPA 101 Interior Wall and	Ceiling Finish			5) Date of compliance: 6/25	22	

	ENT OF DEFICIENCIES	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	N OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		155156	B. WING	01	06/02/2022	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	F PROVIDER OR SUPPLIE	R	1101 E	COOLSPRING AVE		
APERIC	ON CARE ARBORS	MICHIGAN CITY	MICHI	GAN CITY, IN 46360		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	2012 EXISTING					
		ceiling finishes, including				
		surfaces of buildings such				
		ble walls, partitions,				
		ve a flame spread rating of				
		B. The reduction in class of				
		a sprinkler system as				
		2.8.1 is permitted.				
	10.2, 19.3.3.1, 19					
	Indicate flame sp	pread rating(s).				
	Based on observat	ion and interview, the facility	K 0331	K-331 Interior wall and Ceiling	g 06/25/2022	
	failed to ensure ma	aterials used as an interior		finish		
	finish on 1 of 1 sm	hall lounge on the Alzheimer's				
	/ Dementia unit ha	d a flame spread rating of		The facility requests paper		
		3 in accordance with 19.3.3.1.		compliance for this citation.		
		es products required to be				
		ce with ASTM E 84, Standard		This Plan of Correction is the		
		urface Burning Characteristics		center's credible allegation o	f	
	-	ials or ANSI/UL 723, Standard		compliance.		
		e Burning Characteristics of				
		s shall be grouped in the		Preparation and/or execution		
		in accordance with their flame		this plan of correction does r	not	
	spread and smoke	-		constitute admission or	_	
		or Wall and Ceiling Finish.		agreement by the provider of		
	-	; smoke development 0-450.		the truth of the facts alleged	or	
	-	rial classified at 25 or less on		conclusions set forth in the		
	-	est scale and 450 or less on the		statement of deficiencies. The		
		Any element thereof, when so		plan of correction is prepared		
		ontinue to propagate fire. or Wall and Ceiling Finish.		and/or executed solely becau it is required by the provision		
		75; smoke development 0-450.		of federal and state law.		
	_	rial classified at more than 25				
	-	75 on the flame spread test		Immediate actions take	n	
		ess on the smoke test scale.		for those residents identified		
		r Wall and Ceiling Finish.		Flame spread preventio		
		200; smoke development		was adhered to faux wood an		
	-	ny material classified at more		shingled roof , faux header,		
		ore than 200 on the flame		and wood slats located on the	e	

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spread test scale and 450 or less on the smoke

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ceiling in the Alzheimer's unit

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STATEMENT OF DEFIC AND PLAN OF CORREC		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155156	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/02/2022
NAME OF PROVIDER OF			1101 E	ADDRESS, CITY, STATE, ZIP CODE E COOLSPRING AVE GAN CITY, IN 46360	
< , , , , , , , , , , , , , , , , , , ,		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETI DATE
test scale staff only Findings Based or Mainten of the fa area loca had a fau wood sla When as flame sp shingles, none cou rating do DOM at would at soon as p to the clo conferen and the I informat	e. This def y. include: n observat ance (DOI cility at 12 tted on the ix wood sl tts located ked if then read rating header, a ild be prov ocumentati the time of tempt to h possible, b posing of th ce with th DOM at 22 ion or evic to this det	icient practice could affect ions made with the Director of M) on 06/02/22 during a tour 2:51 p.m., the small lounge Alzheimer's / Dementia unit hingled roof, a faux header, and on the ceiling of the room. re was documentation on the g of the aforementioned wood nd ceiling available for review, vided. The lack of flame spread fon was acknowledged by the of observation who stated he ocate any documentation as ut none could be located prior is survey. During the exit e facility Executive Director 45 p.m., no additional dence could be provided ficient finding.		 room 2) How the facility identified other residents: Visitors, staff, and residents that reside at the community have the potential to be affected by the alleged defice practice. 3) Measures put into place/System changes: The Maintenance Director or Designee in serviced on the requirement for fire spread prevention on any faux mater adhered to the facilities interior structure. An audit will be conducted 1 times weekly to identify any new décor needir flame spread prevention. The Maintenance Director is responsible for compliance. How the corrective action will be monitored: The DOM will conduct an inspection on all decoration adhered to the interior of the building to ensure that mater has flame spread preventior. 	ient ient ials or ig is s s rial i.
				• The results of these audits will be reviewed in	
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 OMB NO. 0938-0391

	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	I TIPLE CO	ONSTRUCTION		MB NO. 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	ì í	ILDING	<u>01</u>	· · ·	PLETED
	or conduction	155156	B. WI		01		2/2022
		100100					
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODI	3	
APERIO	N CARE ARBORS	MICHIGAN CITY		MICHIC	GAN CITY, IN 46360		
(X4) ID	SUMMARY			PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Quality Assurance Meeti	-	
					monthly for 6 months or		
					100% compliance is achi		
					The QA Committee will in	-	
					any trends or patterns a		
					make recommendations		
					revise the plan of correc	tion as	
					indicated.		
					5) Date of compliance:	6125122	
					5) Date of compliance.	JIZJIZZ	
K 0353	NFPA 101						
SS=F	-	- Maintenance and Testing					
Bldg. 01	Sprinkler System						
		ler and standpipe systems					
		sted, and maintained in					
	-	NFPA 25, Standard for the					
		ng, and Maintaining of					
		Protection Systems.					
		m design, maintenance,					
		sting are maintained in a					
	secure location a	nd readily available.					
	a) Date sprinkle	r system last checked					
	b) Who provide	d system test					
	c) Water systen	n supply source					
	Provide in REMA	.RKS information on					
		non-required or partial					
	automatic sprinkl						
	9.7.5, 9.7.7, 9.7.8	-					
		vation and interview, the	K 03	53	K-353 Sprinkler System		06/25/2022
		sure 9 of 9 sprinkler heads	IX US				00/25/202
		rance canopy were clean, free			The facility requests pap	er	
		s, and corrosion. NFPA 25,			compliance for this citat		
		2.1.1.1 sprinklers shall not					
		age; shall be free of corrosion,			This Plan of Correction i	s the	
		paint, and physical damage; and			center's credible allegati		
	in and in a second seco	n the correct orientation (e.g.,			compliance.		1

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155156 B. WING 06/02/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 E COOLSPRING AVE APERION CARE ARBORS MICHIGAN CITY MICHIGAN CITY, IN 46360 (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 DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of Preparation and/or execution of the following shall be replaced: (1) Leakage (2) this plan of correction does not Corrosion (3) Physical Damage (4) Loss of fluid constitute admission or agreement by the provider of in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the the truth of the facts alleged or sprinkler manufacturer. This deficient practice conclusions set forth in the could affect all residents, staff and visitors using statement of deficiencies. The the facility main entrance. plan of correction is prepared and/or executed solely because Findings include: it is required by the provisions of federal and state law. Based on observations made with the Director of Maintenance (DOM) on 06/02/22 during a tour Immediate actions taken for those residents identified: of the facility at 12:30 p.m., all nine sprinklers located under the main entrance canopy were all All nine sprinkler heads covered in corrosion, cobwebs, and foreign under the canopy are scheduled to be replaced by material. This was verified by the DOM at the time of the observation who added that he would Safe Care on 6-20-22 have his vendor replace the dirty sprinkler heads The dry fire system was as soon as he could. During the exit conference inspected and documented that with the facility Executive Director and the its functioning and in working order. DOM at 2:45 p.m., no additional information or evidence could be provided contrary to this 2) How the facility identified other residents: deficient finding. 3.1-19(b) Visitors, staff, and residents that reside at the community 2) Based on record review, and interview; the have the potential to be facility failed to document sprinkler system affected by the alleged deficient inspections in accordance with NFPA 25. NFPA practice. 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection 3) Measures put into place/ System changes: Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good The Maintenance condition and that normal water supply pressure Director or Designee in serviced on the weekly is being maintained. Section 5.1.2 states valves and fire department connections shall be inspection and documentation inspected, tested, and maintained in accordance of the dry Fire System

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 B. WING 155156 06/02/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 E COOLSPRING AVE APERION CARE ARBORS MICHIGAN CITY MICHIGAN CITY, IN 46360 (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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) with Chapter 13. Section 13.1.1.2 states Table The Maintenance 13.1.1.2 shall be utilized for inspection, testing Director is responsible for and maintenance of valves, valve components and compliance. trim. Section 4.3.1 states records shall be made 4. How the corrective actions will be monitored: for all inspections, tests, and maintenance of the system and its components and shall be made The ED will conduct an available to the authority having jurisdiction upon audit will be conducted 1 day a request. This deficient practice could affect all week to ensure that the alleged residents and staff in the facility. deficient practice does not occur. Findings include: The Executive Director Based on review of the facilities sprinkler will review the Preventative system inspections entitled "Sprinkler: Report of **Maintenance Worksheets** Inspection" documentation dated 02/16/22, monthly. 05/18/22, 08/02/2021, and 11/04/2022, with the Director of Maintenance (DOM) the facility was The results of these found to have both a wet and a dry sprinkler audits will be reviewed in system. Review of the facilities documentation **Quality Assurance Meeting** listed only monthly inspections of the riser monthly for 6 months or until gauges and control valves as being inspected. 100% compliance is achieved. The QA Committee will identify There was no available documentation at the time of this survey to support weekly control valve any trends or patterns and and gauge inspections on the dry sprinkler make recommendations to revise the plan of correction as system. Based on interview at the time of record review, the DOM acknowledged that monthly indicated. sprinkler system gauge inspections were being completed but added that he did not know about 5) Date of compliance: 6/25/22 the requirement for the weekly control valve and gauge inspections on the dry sprinkler system. During the exit conference with the facility Executive Director and the DOM at 2:45 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) K 0374 **NFPA 101** SS=E Subdivision of Building Spaces - Smoke Bldg. 01 Barrie

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M21 Facility ID:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	x1) provider/supplier/clia identification number: 155156	A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/02/2022	
NAME OF PROVIDER OR SUPPLE		110 ⁻	ET ADDRESS, CITY, STATE, ZIP (1 E COOLSPRING AVE HIGAN CITY, IN 46360	CODE		
	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION S	HOULD BE C	(X5) OMPLETIO	
TAG REGULATORY	OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY	APPROPRIATE	DATE	
Barrier Doors2012 EXISTINGDoors in smokesolid bonded wayconstruction thatNonrated protectare permitted. Dfixed fire windoware self-closingrequire latchingswing in the direopening provide32 inches for sw19.3.7.6, 19.3.7Based on observationfailed to ensure 1doors would restriatat least 20 minuterequires that doorcomply with LSC8.5.4.1 requires dothe opening leavinecessary for proas 1/8 inch to restThis deficient prawell as 3 staff andFindings includesBased on observationMaintenance (DC)of the facility at 1resident room #2latch leaving a ofwhere the doors ofposition. Based ofobservation, the 1the doors not full	barriers are 1-3/4-inch thick bod-core doors or of t resists fire for 20 minutes. tive plates of unlimited height boors are permitted to have v assemblies per 8.5. Doors or automatic-closing, do not and are not required to ection of egress travel. Door is a minimum clear width of vinging or horizontal doors. .8, 19.3.7.9 tion and interview, the facility of 4 sets of smoke barrier ict the movement of smoke for es. LSC, Section 19.3.7.8 rs in smoke barriers shall C, Section 8.5.4. LSC, Section oors in smoke barriers to close ing only the minimum clearance per operation which is defined trict the movement of smoke. actice affects 28 residents, as d 2 visitors.	К 0374	K-374 Smoke Barrier The facility requests compliance for this c This Plan of Correctio center's credible aller compliance. Preparation and/or ex- this plan of correctio constitute admission agreement by the pro- the truth of the facts conclusions set forth statement of deficien plan of correction is and/or executed soler it is required by the pro- of federal and state later Immediate active for those residents in The door near fresident room #233 w	paper itation. on is the gation of alleged or or in the prepared ly because provisions aw. ons taken lentified: the	6/25/20	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155156	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 06/02/2022	
	PROVIDER OR SUPPLIE		1101 E	ADDRESS, CITY, STATE, ZIP CODE COOLSPRING AVE GAN CITY, IN 46360		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETI DATE	
	doors repaired. Du the facility Execut 2:45 p.m., no addi	ring the exit conference with ive Director and the DOM at tional information or evidence contrary to this deficient		repaired and inspected to ensure proper closing and latching. All other smoke barrier doors were inspected for latching and proper close 2) How the facility identified other residents: Visitors, staff, and residents that reside at the community have the potential to be affected by the alleged defici- practice. 3) Measures put into place/ System changes: • The Maintenance Director or Designee in serviced on the inspection a documentation of the Fire barrier doors properly closin and latching • The Maintenance Director is responsible for compliance. 4. How the corrective action will be monitored: • The ED will conduct ar audit will be conducted 1 day week to ensure that the alleg deficient practice does not occur.	ent nd g s n /a ed	
				• The results of these		

ENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155156		A. BL	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 06/02/2022		
NAME OF	PROVIDER OR SUPPLIE	R	_		ADDRESS, CITY, STATE, ZIP CODE COOLSPRING AVE		
APERIO	N CARE ARBORS	MICHIGAN CITY		MICHIC	GAN CITY, IN 46360		
(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 EFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
					audits will be reviewed in Quality Assurance Meetin monthly for 6 months or u 100% compliance is achie The QA Committee will idu any trends or patterns and make recommendations to revise the plan of correcti indicated.	intil ved. entify d	
(0511 SS=E Bldg. 01	complies with NF Code, electrical v complies with NF	d Electric gas or related gas piping PA 54, National Fuel Gas viring and equipment PA 70, National Electric stallations can continue in no hazard to life.					
	Based on observati failed to ensure all corridors were secu personnel. NFPA 7 2011 edition states equipment shall be 230.62(A) or guard (A) Enclosed. Ener so that they will no contact or shall be (B) Guarded. Ener enclosed shall be in panelboard, or con accordance with 11 energized parts are 110.27(A)(1) and (on and interview, the facility electrical panels in the ured from non-authorized 70, National Electric Code, energized parts of service enclosed as specified in led as specified in 230.62(B). rgized parts shall be enclosed of be exposed to accidental guarded as in 230.62(B). gized parts that are not nstalled on a switchboard, trol board and guarded in 10.18 and 110.27. Where guarded as provided in A)(2), a means for locking or iding access to energized parts	К 0.	511	K-511 Gas Electric The facility requests paper compliance for this citation This Plan of Correction is center's credible allegation compliance. Preparation and/or execut this plan of correction do constitute admission or agreement by the provide the truth of the facts alleg conclusions set forth in the statement of deficiencies. plan of correction is preparation	on. the on of tion of es not r of red or he . The ared	06/25/202

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 B. WING 06/02/2022 155156 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 E COOLSPRING AVE APERION CARE ARBORS MICHIGAN CITY MICHIGAN CITY, IN 46360 (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 DATE TAG DEFICIENCY) This deficient practice could affect all 54 it is required by the provisions residents, 6 staff and 2 visitors. of federal and state law. Immediate actions taken Findings include: for those residents identified: Based on observations made with the Director of The electrical panel on Maintenance (DOM) on 06/02/22 during a tour the Alzheimer's Unit was locked and secured of the facility from 12:30 p.m. to 2:31 p.m. the following electrical panel locations in the The two electrical panels corridor were each not locked or secured: located outside the laundry a. the two electrical panels on the Alzheimer's / room were locked and secure. Dementia unit near the nurse's station All other electrical panels were b. the two electric panels located outside the check to ensure they were locked and secure. laundry room Based on interview at the time of each 2) How the facility identified observation, the DOM agreed that the other residents: aforementioned electrical panels in the corridor were not secured from non-authorized personnel Visitors, staff, and residents and added that he would have them secured that reside at the community immediately. During the exit conference with the have the potential to be facility Executive Director and the DOM at 2:45 affected by the alleged deficient p.m., no additional information or evidence could practice. be provided contrary to this deficient finding. 3) Measures put into place/ 3.1-19(b) System changes: The Maintenance **Director or Designee in** serviced locking and securing electrical panels The Maintenance Director is responsible for compliance. 4. How the corrective actions will be monitored: The DOM/designee will conduct an audit will be conducted 1 day a week to ensure that the alleged deficient practice does not

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	R MEDICARE & MEDIONT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	II TIPI E CO	NSTRUCTION	-	MB NO. 0938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155156		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 06/02/2022			
NAME OF 1	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE	I	
APERIO	N CARE ARBORS	MICHIGAN CITY		MICHIG	AN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRC DEFICIENCY)		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	OCCUR.		DATE
					• The Executive Dire will review the Preventati Maintenance Worksheets monthly.	ve	
					The results of these audits will be reviewed in Quality Assurance Meetin monthly for 6 months or a 100% compliance is achie The QA Committee will id any trends or patterns an make recommendations of revise the plan of correct indicated.	ng until eved. lentify d	
K 0712 SS=F Bldg. 01	alarm signal and fire conditions. F expected and un varying condition shift. The staff is and is aware tha routine. Where of 9:00 PM and 6:0 announcement n audible alarms. 19.7.1.4 through Based on record re facility failed to co	nay be used instead of 19.7.1.7 eview and interview, the onduct quarterly fire drills for	K 0'	712	5) Date of compliance: 6 K-712 Fire Drills		06/25/202
	be conducted quar	C 19.7.1.6 requires drills to terly on each shift under varied eficient practice affects all			The facility requests pape compliance for this citation		

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 B. WING 06/02/2022 155156 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 E COOLSPRING AVE APERION CARE ARBORS MICHIGAN CITY MICHIGAN CITY, IN 46360 (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) residents, staff, and visitors. This Plan of Correction is the center's credible allegation of Findings include: compliance. Based on record review with the Director of Preparation and/or execution of Maintenance (DOM) on 06/02/22 at 9:30 a.m. this plan of correction does not the following was noted: constitute admission or 1) documentation of a first, second, or third shift agreement by the provider of fire drill or acceptable staff training could not be the truth of the facts alleged or conclusions set forth in the located for review for the first quarter (January, February, or March) of 2022. statement of deficiencies. The 2) documentation of a first, second, or third shift plan of correction is prepared fire drill or acceptable staff training could not be and/or executed solely because it is required by the provisions located for review for the second quarter (April of federal and state law. and May) of 2022 or June of 2021. 3) documentation of a first, second, or third shift fire drill or acceptable staff training could not be Immediate actions taken for those residents identified: located for review for the third quarter (July, Fire drills were August, or September) of 2021. 4) documentation of a second or third shift fire completed all 3 shifts at various drill or acceptable training could be provided times to place facility in regarding a fire drill for the fourth quarter compliance of conducting fire drills at least quarterly on all 3 (October, November, or December) of 2021. Based on interview at the time of record review, shifts. the DOM acknowledged that there was no 2) How the facility identified additional available fire drill documentation other residents: available for review at the time of this survey. During the exit conference with the facility Visitors, staff, and residents Executive Director and the DOM at 2:45 p.m., no that reside at the community additional information or evidence could be have the potential to be provided contrary to this deficient finding. affected by the alleged deficient practice. 3.1-19(b) 3) Measures put into place/ 3.1-51(c) System changes: The Maintenance Director or Designee in serviced on regulatory requirements for fire drills

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	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		OMB NO. 0938-039 TE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155156			(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u>			COMPLETED	
			B. WING	01	-	02/2022	
			STR	REET ADDRESS, CITY, STATE, ZIP CO	- DDF		
NAME OF	PROVIDER OR SUPPLIE	R		01 E COOLSPRING AVE	JDL		
APERIO	N CARE ARBORS	MICHIGAN CITY		CHIGAN CITY, IN 46360			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		-		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREF	PROVIDER'S PLAN OF CORF	OULD BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	G CROSS-REFERENCED TO THE A DEFICIENCY)	CROSS-REFERENCED TO THE APPROPRIATE		
				• The Maintenanc	e		
				Director is responsible	e for		
				compliance.			
				4. How the corrective	actions		
				will be monitored:			
				The ED/designe			
				conduct an audit mon	-		
				ensure that the alleged deficient practice does			
				occur.	5 1101		
				• The Executive D	irector		
				will review the Preven	tative		
				Maintenance Workshe	ets		
				monthly.			
				• The results of th	000		
				audits will be reviewed			
				Quality Assurance Me			
				monthly for 6 months	-		
				100% compliance is a	chieved.		
				The QA Committee wi	ll identify		
				any trends or patterns			
				make recommendation			
				revise the plan of corr indicated.	ection as		
				indicated.			
				5) Date of compliance	: 6/25/22		
0781	NFPA 101						
SS=E	Portable Space H	leaters					
Bldg. 01	Portable Space I						
	Portable space h	eating devices shall be					
		ealth care occupancies,					
		sed in nonsleeping staff and					
		where the heating elements					
		2 degrees Fahrenheit (100					
	degrees Celsius) 18.7.8, 19.7.8						
		ion and interview, the facility	K 0781	K-781 Portable Space	Heaters	06/25/202	
	Based on observat	ion and multilew, the facility	KU/81		1 1001013	1 00/23/202	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 B. WING 06/02/2022 155156 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 E COOLSPRING AVE APERION CARE ARBORS MICHIGAN CITY MICHIGAN CITY, IN 46360 (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) failed to ensure 1 of 1 portable space heater was not used in the facility. NFPA 101 Life Safety The facility requests paper Code at 19.7.8 states Portable space heating compliance for this citation. devices shall be prohibited in all health care This Plan of Correction is the occupancies. Unless used in nonsleeping staff and employee areas where the heating elements center's credible allegation of do not exceed 212 degrees Fahrenheit (100 compliance. degrees Celsius). This deficient practice could affect 12 residents, 8 staff and 4 visitors in the Preparation and/or execution of vicinity of the main lobby area. this plan of correction does not constitute admission or agreement by the provider of Findings include: the truth of the facts alleged or Based on observations made upon entering the conclusions set forth in the facility at 9:14 a.m., it was noted that a faux statement of deficiencies. The fireplace / portable space heater was located in plan of correction is prepared the main lobby waiting area. After introductions and/or executed solely because were made and a COVID-19 screening was it is required by the provisions completed, the staff contacted the Director of of federal and state law. Maintenance (DOM). Further investigation noted that the faux fireplace was turned on and was Immediate actions taken generating heat into the lobby area. Based on an for those residents identified: Portable space heater interview after the arrival of the DOM, he looked at the faux fireplace and stated that he did not was removed from the lobby know it generated heat or was working. He then 2) How the facility identified unplugged the faux fireplace, and we began other residents: walking through the facility for the pre-tour of the building. The DOM was then asked if he Visitors, staff, and residents could provide any manufacturers documentation that reside at the community on the faux fireplace and he replied he would have the potential to be look into getting me the documentation. Shortly affected by the alleged deficient thereafter it was determined that the practice. manufacturers documentation for the faux 3) Measures put into place/ fireplace / portable space heater could not be located. Based on further interview at that time System changes: the DOM the acknowledged the faux fireplace / portable space heater was use in the lobby area The Maintenance and that documentation for said item could not Director or Designee in be located for review to determine if it met serviced on regulatory acceptable limits for use within the facility. requirements for portable

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01		COMPLETED	
		155156	B. WING		06/02/2022	
	PROVIDER OR SUPPLIE		1101 E	ADDRESS, CITY, STATE, ZIP CODE E COOLSPRING AVE GAN CITY, IN 46360	•	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID			(X5)
PREFIX		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR	E	COMPLETION
TAG	During the exit cor Executive Director additional informat	A LSC IDENTIFYING INFORMATION) inference with the facility and the DOM at 2:45 p.m., no tion or evidence could be to this deficient finding.	TAG	space heater The Maintenance Director is responsible for compliance. 4. How the corrective action will be monitored: The ED/designee will conduct an audit on any ner- heating elements brought in the facility to ensure that the meet the regulatory requirement and the facilitie policies The Executive Direct will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or un 100% compliance is achiev The QA Committee will iden any trends or patterns and make recommendations to revise the plan of correctio indicated. 5) Date of compliance: 6/2	l ew n to ney es or or or or or or n til ed. ntify	DATE

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