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	06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN 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 (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: 06/02/22 Facility Number: 000076 Provider Number: 155156 AIM Number: 100271060 At this Emergency Preparedness survey, Aperion Care Arbors at Michigan City was found 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 115. Quality Review completed on 06/06/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/02/22 Facility Number: 000076 Provider Number: 155156	K 0000		

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

Any defiencystatement 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.

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	AIM Number: 100271060 At this Life Safety Code survey, Aperion Care Arbors at 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 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 115. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 06/06/22			
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			

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	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 staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 8 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 34 residents, 4 staff and 2 visitors. Findings include: Based on observations made with the Director of Maintenance (DOM) on 06/02/22 during a tour of the facility from 12:30 p.m. to 2:31 p.m. the following was noted: 1) a PCV constructed cart containing 25 washrags, 15 bath towels, 5 bedsheets, 5 patient gowns, and 3 blankets was stored in the corridor outside resident room #109 and was not currently in use. 2) a PCV constructed cart containing 20	K 0211	**K-221 Means to Egress** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***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.*** · **Immediate actions taken for those residents identified:** · **The DOM ensured All PVC carts were removed from hallways including** · **The carts outside rooms #109 #125** · **The isolation cart outside of #214 was replaced with a wheeled isolation cart.** · **Pallet was removed from the hallway near room #222** · **PCV cart was removed from the 300 room area.**	06/25/2022

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	washrags, 5 bath towels, 4 bedsheets, 8 patient gowns, and 5 blankets was stored in the corridor outside resident room #125 and was not currently in use. 3) a small 3 drawer cart containing miscellaneous contact isolation items was stored in the corridor immediately outside resident room #214 and was not on wheels. 4) an empty delivery pallet was sitting on the floor in the corridor immediately outside resident room #222 and was not in use or attended. 5) a PCV constructed cart containing 15 washrags, 6 bath towels, 4 bedsheets, 3 patient gowns, and 2 packages of adult diapers was stored in the corridor outside resident room #306 and was not currently in use. Based on interview with the DOM at the time of each observation, he acknowledged the items in the corridor and were not supposed to be stored there or left unattended and stated that he would hold an in-service for staff in hopes of remedying this issue. 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)		**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 deficient practice.** **3) Measures put into place/ System changes:** · **The Maintenance Director or Designee in serviced the staff on the means to egress and not having carts and non-emergency equipment in the hallway. 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.** **4. How the corrective actions will be monitored:** · **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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			any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 6/25/22**	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored			

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	at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 3 of 4 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise	K 0222	**K-222** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.***	06/25/2022

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	permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 48 residents, 8 staff and 4 visitors if needing to exit the facility. Findings include: Based on observations made with the Director of Maintenance (DOM) on 06/02/22 during a tour of the facility from 12:30 p.m. to 2:31 p.m. the 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 was not posted at the exit: 1) the entry / exit leading to the facility designated smoking area. 2) the entry / exit to the employee parking lot. 3) the entry / exit leading to the Physical Therapy room. 4) the entry / exit outside the Physical Therapy area. 5) the 400 Hall exit near resident rooms #416 and #417. 6) the 400 Hall exit nearest to the Social Services office. Based on interview at the time of the observations, the DOM stated the aforementioned facility exits were indeed marked as exits and could be opened by entering a four-digit code, but the code was not posted adding that some of the door keypads were not functioning properly and that his Vendor was scheduled to come repair or replace them in the near future. 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.		***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.*** · **Immediate actions taken for those residents identified:** · **All exits were labeled visibly with a four digit code including but not limited to** · **The entry/exit leading to the facility designated smoking area** · **The entry/exit to the employee parking lot** · **The entry exit leading to the therapy room** · **The entry/exit outside the therapy room** · **The 400 hall exit near resident rooms #416 and #417** · **The 400 hall exit nearest the Social Services office** **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 deficient practice.**	

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	3.1-19(b)		**3) Measures put into place/ System changes:** · **The Maintenance Director or Designee in serviced the staff on ensuring that door codes are visible at all times to staff, residents and 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.** **4. How the corrective actions will be monitored:** · **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 any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 6/25/22**	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish			

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	2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). ________________________			
	Based on observation and interview, the facility failed to ensure materials used as an interior finish on 1 of 1 small lounge on the Alzheimer's / Dementia unit had a flame spread rating of Class A or Class B in accordance with 19.3.3.1. LSC 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke	K 0331	**K-331 Interior wall and Ceiling finish** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***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.*** · **Immediate actions taken for those residents identified:** · **Flame spread prevention was adhered to faux wood and shingled roof , faux header, and wood slats located on the ceiling in the Alzheimer's unit**	06/25/2022

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	test scale. This deficient practice could affect staff only. Findings include: Based on observations made with the Director of Maintenance (DOM) on 06/02/22 during a tour of the facility at 12:51 p.m., the small lounge area located on the Alzheimer's / Dementia unit had a faux wood shingled roof, a faux header, and wood slats located on the ceiling of the room. When asked if there was documentation on the flame spread rating of the aforementioned wood shingles, header, and ceiling available for review, none could be provided. The lack of flame spread rating documentation was acknowledged by the DOM at the time of observation who stated he would attempt to locate any documentation as soon as possible, but none could be located prior to the closing of this survey. 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)		**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 deficient 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 materials adhered to the facilities interior structure. An audit will be conducted 1 times weekly to identify any new décor needing flame spread prevention. · **The Maintenance Director is responsible for compliance.** **4. How the corrective actions will be monitored:** **The DOM will conduct an inspection on all decorations adhered to the interior of the building to ensure that material has flame spread prevention.** · **The Executive Director will review the Preventative Maintenance Worksheets monthly.** · **The results of these audits will be reviewed in**	

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			Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 6/25/22**	
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 observation and interview, the facility failed to ensure 9 of 9 sprinkler heads under the main entrance canopy were clean, free of foreign materials, and corrosion. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g.,	K 0353	**K-353 Sprinkler System** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.***	06/25/2022

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	up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect all residents, staff and visitors using the facility main entrance. Findings include: Based on observations made with the Director of Maintenance (DOM) on 06/02/22 during a tour of the facility at 12:30 p.m., all nine sprinklers located under the main entrance canopy were all covered in corrosion, cobwebs, and foreign material. This was verified by the DOM at the time of the observation who added that he would have his vendor replace the dirty sprinkler heads as soon as he could. 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) 2) Based on record review, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection 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 condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance		***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.*** · **Immediate actions taken for those residents identified:** · **All nine sprinkler heads under the canopy are scheduled to be replaced by Safe Care on 6-20-22** · **The dry fire system was inspected and documented that its functioning and in working order.** **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 deficient practice.** **3) Measures put into place/ System changes:** · **The Maintenance Director or Designee in serviced on the weekly inspection and documentation of the dry Fire System**	

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	155156	A. BUILDING 01 B. WING	06/02/2022

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APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

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	with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents and staff in the facility. Findings include: Based on review of the facilities sprinkler system inspections entitled "Sprinkler: Report of Inspection" documentation dated 02/16/22, 05/18/22, 08/02/2021, and 11/04/2022, with the Director of Maintenance (DOM) the facility was found to have both a wet and a dry sprinkler system. Review of the facilities documentation listed only monthly inspections of the riser gauges and control valves as being inspected. There was no available documentation at the time of this survey to support weekly control valve and gauge inspections on the dry sprinkler system. Based on interview at the time of record review, the DOM acknowledged that monthly sprinkler system gauge inspections were being completed but added that he did not know about 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)		· **The Maintenance Director is responsible for compliance.** **4. How the corrective actions will be monitored:** · **The ED will conduct an audit will be conducted 1 day a week to ensure that the alleged deficient practice does not occur.** · **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 any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 6/25/22**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie			

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	Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9			
	Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 28 residents, as well as 3 staff and 2 visitors. Findings include: Based on observations made with the Director of Maintenance (DOM) on 06/02/22 during a tour of the facility at 1:20 p.m., the barrier doors near resident room #233 failed to fully close and latch leaving a one-inch gap along the center where the doors came together to the closed position. Based on an interview at the time of the observation, the DOM stated that he was aware of the doors not fully closing and latching and stated that he was working towards getting the	K 0374	**K-374 Smoke Barrier Doors** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***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.*** · **Immediate actions taken for those residents identified:** · **The door near the resident room #233 was**	06/25/2022

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	doors repaired. 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)		**repaired and inspected to ensure proper closing and latching. All other smoke barrier doors were inspected for latching and proper closer.** **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 deficient practice.** **3) Measures put into place/ System changes:** · **The Maintenance Director or Designee in serviced on the inspection and documentation of the Fire barrier doors properly closing and latching** · **The Maintenance Director is responsible for compliance.** **4. How the corrective actions will be monitored:** · **The ED will conduct an audit will be conducted 1 day a week to ensure that the alleged deficient practice does not occur.** · **The Executive Director will review the Preventative Maintenance Worksheets monthly.** · **The results of these**	

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			audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 6/25/22**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2			
	Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, National Electric Code, 2011 edition states energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided.	K 0511	**K-511 Gas Electric** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***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***	06/25/2022

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	This deficient practice could affect all 54 residents, 6 staff and 2 visitors. Findings include: Based on observations made with the Director of Maintenance (DOM) on 06/02/22 during a tour of the facility from 12:30 p.m. to 2:31 p.m. the following electrical panel locations in the corridor were each not locked or secured: a. the two electrical panels on the Alzheimer's / Dementia unit near the nurse's station b. the two electric panels located outside the laundry room Based on interview at the time of each observation, the DOM agreed that the aforementioned electrical panels in the corridor were not secured from non-authorized personnel and added that he would have them secured immediately. 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)		***it is required by the provisions of federal and state law.*** · **Immediate actions taken for those residents identified:** · **The electrical panel on the Alzheimer's Unit was locked and secured** · **The two electrical panels located outside the laundry room were locked and secure. All other electrical panels were check to ensure they were locked and secure.** **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 deficient practice.** **3) Measures put into place/ 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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			occur. · **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 any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 6/25/22**	
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 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 quarterly fire drills for 4 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all	K 0712	**K-712 Fire Drills** **The facility requests paper compliance for this citation.**	06/25/2022

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	residents, staff, and visitors. Findings include: Based on record review with the Director of Maintenance (DOM) on 06/02/22 at 9:30 a.m. the following was noted: 1) documentation of a first, second, or third shift fire drill or acceptable staff training could not be located for review for the first quarter (January, February, or March) of 2022. 2) documentation of a first, second, or third shift fire drill or acceptable staff training could not be located for review for the second quarter (April 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 located for review for the third quarter (July, August, or September) of 2021. 4) documentation of a second or third shift fire drill or acceptable training could be provided regarding a fire drill for the fourth quarter (October, November, or December) of 2021. Based on interview at the time of record review, the DOM acknowledged that there was no additional available fire drill documentation available for review at the time of this survey. 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) 3.1-51(c)		***This Plan of Correction is the center's credible allegation of compliance.*** ***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.*** · **Immediate actions taken for those residents identified:** · **Fire drills were completed all 3 shifts at various times to place facility in compliance of conducting fire drills at least quarterly on all 3 shifts.** **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 deficient practice.** **3) Measures put into place/ System changes:** · **The Maintenance Director or Designee in serviced on regulatory requirements for fire drills**	

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			· **The Maintenance Director is responsible for compliance.** **4. How the corrective actions will be monitored:** · **The ED/designee will conduct an audit monthly to ensure that the alleged deficient practice does not occur.** · **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 any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 6/25/22**	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility	K 0781	**K-781 Portable Space Heaters**	06/25/2022

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	failed to ensure 1 of 1 portable space heater was not used in the facility. NFPA 101 Life Safety Code at 19.7.8 states Portable space heating devices shall be prohibited in all health care occupancies. Unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). This deficient practice could affect 12 residents, 8 staff and 4 visitors in the vicinity of the main lobby area. Findings include: Based on observations made upon entering the facility at 9:14 a.m., it was noted that a faux fireplace / portable space heater was located in the main lobby waiting area. After introductions were made and a COVID-19 screening was completed, the staff contacted the Director of Maintenance (DOM). Further investigation noted that the faux fireplace was turned on and was generating heat into the lobby area. Based on an interview after the arrival of the DOM, he looked at the faux fireplace and stated that he did not know it generated heat or was working. He then unplugged the faux fireplace, and we began walking through the facility for the pre-tour of the building. The DOM was then asked if he could provide any manufacturers documentation on the faux fireplace and he replied he would look into getting me the documentation. Shortly thereafter it was determined that the manufacturers documentation for the faux fireplace / portable space heater could not be located. Based on further interview at that time the DOM the acknowledged the faux fireplace / portable space heater was use in the lobby area and that documentation for said item could not be located for review to determine if it met acceptable limits for use within the facility.		**The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***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.*** · **Immediate actions taken for those residents identified:** · **Portable space heater was removed from the lobby** **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 deficient practice.** **3) Measures put into place/ System changes:** · **The Maintenance Director or Designee in serviced on regulatory requirements for portable**	

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	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)		**space heater** · **The Maintenance Director is responsible for compliance.** **4. How the corrective actions will be monitored:** · **The ED/designee will conduct an audit on any new heating elements brought in to the facility to ensure that they meet the regulatory requirement and the facilities policies** · **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 any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 6/25/22**	