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	06/10/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	A Emergency Preparedness Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/10/21 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 106. Quality Review completed on 06/11/21	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: 06/10/21 Facility Number: 000076 Provider Number: 155156	K 0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 01 B. WING	06/10/2021

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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 an 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 106. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 06/11/21			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70,			

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	National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants. Findings include: Based on record review from 10:45 a.m. to 1:55 p.m. with the Maintenance Director on 06/10/21, the last fire alarm report dated 4/22/21 by the facility's fire alarm vendor was the annual inspection. The report indicated "Door holders - Door towards training room Left & Right failed." Further record review showed the same door holders failed on the 4/6/2020 annual fire alarm inspection. Based on interview at the time of record review, the Maintenance Director acknowledged the issue, stated the vendor did not mention the issue but was unable to show documentation showing repairs have been made or were scheduled to be repaired. This finding was reviewed with the Executive Director at the exit conference. 3.1-19(b)	K 0345	K345 The facility requests paper compliance for this citation. The plan of correction is the centers 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. **1.Immediate actions taken for those residents identified.** ·Facility immediately contacted vendor and repairs completed. **1.How the facility identified other residents.** All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. All door drops inspected and working properly. **1.Measures put into place/System changes:** ·An audit will be completed by the maintenance director or	07/09/2021

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			designee weekly ·The Maintenance Director is responsible for compliance. **1. How the corrective actions will be monitored:** **·An environmental QAPI tool will be utilized weekly x 4 and monthly thereafter, to monitor compliance** **·The results of these audits used will be reviewed Quality Assurance meeting monthly for 6 months or until 100% compliance is achieved by administrator or designee The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **1. Date of Compliance:** **·7/9/21**	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific			

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	areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads in the facility were installed in accordance with NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 6.2.7.2 states escutcheons used with recessed, flush-type or concealed sprinklers shall be part of a listed sprinkler assembly. Section 6.2.7.3 states cover plates used with concealed sprinklers shall be part of the listed sprinkler assembly. This deficient practice could affect over 10 residents, staff and visitors in the 100 Hall and kitchen. Based on observations with the Maintenance Director during a tour of the facility from 1:55 p.m. to 4:00 p.m. on 06/10/21 the following was noted: a. the ceiling mounted sprinkler in the kitchen by the walk in refrigerator was missing it's escutcheon. b. the ceiling mounted sprinkler in 100 east hall by the fire doors was missing it's escutcheon. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned sprinkler locations were missing their escutcheons. This finding was reviewed with the Executive Director at the time of exit.	K 0351	K351 The facility requests paper compliance for this citation. The plan of correction is the centers 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. **1.Immediate actions taken for those residents identified.** ·Escutcheons were immediately installed to ensure proper barrier. **2. How the facility identified other residents.** **No** residents, staff and visitors were affected by the alleged deficient practice. **3 Measures put into**	07/09/2021

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	3.1-19(b)		**place/System changes** ·An audit will be completed by the maintenance director or designee weekly x's 4 weeks then monthly to ensure compliance. ·The Maintenance Director is responsible for compliance. ·Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **4 How the corrective actions will be monitored** **·An environmental QAPI tool will be utilized weekly x 4 and monthly thereafter, to monitor compliance** **·The results of these audits used will be reviewed Quality Assurance meeting monthly for 6 months or until 100% compliance is achieved by administrator or designee. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **1. Date of Compliance:** **·7/9/21**	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in			

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	accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on record review, observation and interview; the facility failed to ensure 1 of 39 portable fire extinguishers had documented annual maintenance in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect over 5 residents and staff near the 400 Hall salon. Findings include: Based on review of the portable fire extinguisher inspection contractor's annual inspection documentation with the Maintenance Director during record review from 10:45 a.m. to 1:55 p.m. on 06/10/21, annual maintenance was performed for 39 portable fire extinguishers in the facility on 04/22/21. Based on observations with the Maintenance Director during a tour of the facility from 1:55 p.m. to 4:00 p.m. on 06/10/21, the wall mounted ABC type portable fire extinguisher located in the salon by the 400 Hall nurse's station had an affixed maintenance tag by the contractor indicating the date the most recent annual maintenance was performed March 2019. Based	K 0355	K355 The facility requests paper compliance for this citation. The plan of correction is the centers 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. 1.Immediate actions taken for those residents identified. ·Facility immediately replaced fire extinguisher. 1.How the facility identified other residents. All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. All fire extinguishers were checked to ensure compliance.	07/09/2021

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	on interview at the time of the observation, the Maintenance Director agreed the aforementioned portable fire extinguisher had an affixed maintenance tag documenting the date the most recent annual maintenance was performed over a year ago. He further stated that this salon is not used, and the contractor must have missed this ABC type portable fire extinguisher on 04/22/2021. This finding was reviewed with the Executive Director at the time of exit. 3-1.19(b)		1.Measures put into place/System changes: ·An audit will be completed by the maintenance director or designee monthly ·The Maintenance Director is responsible for compliance. 1. How the corrective actions will be monitored: ·An environmental QAPI tool will be utilized weekly x 4 and monthly thereafter, to monitor compliance ·The results of these audits used will be reviewed Quality Assurance meeting monthly for 6 months or until 100% compliance is achieved by administrator or designee. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 1. Date of Compliance: ·7/9/21	

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K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:55 p.m.	K 0372	K372 The facility requests paper compliance for this citation. The plan of correction is the centers 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. 1.Immediate actions taken for those residents identified.	07/09/2021

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	to 4:00 p.m. on 06/10/21, penetration openings in the ceiling smoke barrier that were not firestopped were found at the following locations: a. the lobby by the reception desk b. 100 east hall by fire doors c. ceiling mounted sprinkler in the main dining room Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned openings in the ceiling smoke barrier were not protected to maintain the fire resistance rating of the ceiling smoke barrier. This finding was reviewed with the Executive Director at the time of exit. 3.1-19(b)		·Facility immediately installed cover plates to ensure proper barrier 1.How the facility identified other residents. No Residents, staff and visitors were affected by the alleged deficient practice. 1.Measures put into place/System changes: ·An audit will be completed by the maintenance director or designee monthly ·The Maintenance Director is responsible for compliance. ·Residents, staff and visitors have the potential to be affected by the alleged deficient practice. 1. How the corrective actions will be monitored: ·An environmental QAPI tool will be utilized weekly x 4 and monthly thereafter, to monitor compliance ·The results of these audits	

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			used will be reviewed Quality Assurance meeting monthly for 6 months or until 100% compliance is achieved by administrator or designee.. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 1. Date of Compliance: ·7/9/21	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and			

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	associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing at all resident rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include: Based on record review with the Maintenance Director from 10:45 a.m. to 1:55 p.m. on 06/10/21, an itemized listing of the inspection and testing	K 0914	**K914 ELECTRICAL SYSTEM** **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.* **1)Immediate actions taken for those residents identified:** ·There were no residents affected in regard to this regulation. ·Non- hospital grade electrical receptable annual testing audit will be completed by 7/9/21. **2) How the facility identified other residents:** ·Residents, staff and visitors	07/09/2021

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	electrical outlet receptacles at patient bed locations within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated most outlets in resident room are not hospital grade as far as he knew, and acknowledged an itemized listing of the inspection and testing electrical outlet receptacles at patient bed locations within the most recent twelve month period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 1:55 p.m. to 4:00 p.m. on 06/10/21, each resident sleeping room had multiple electrical receptacles installed at resident bed locations which were not hospital-grade receptacles. This finding was reviewed with the Executive Director at the time of exit.		have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** ·The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Executive Director/designee by 7/9/21. **4) How the corrective actions will be monitored:** ·An Environmental QAPI tool will be utilized monthly to monitor compliance. ·The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved by administrator or designee. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated **5) Date of compliance:** 7/9/21	