| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).<br><br>Survey Date: 01/20/16<br><br>Facility Number: 000076<br>Provider Number: 155156<br>AIM Number: 100271060<br><br>At this Life Safety Code survey, Arbors at Michigan City was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>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 hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 180 and had a census of 114 at the time of this survey. | 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<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.<br><br>Quality Review completed on 01/27/16 - DA | | | |
| K 0018<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3<br><br>Roller latches are prohibited by CMS regulations in all health care facilities.<br>1. Based on observation, the facility failed to ensure 1 of 115 resident room doors were capable of resisting smoke for at least 1/2 hour. This deficient practice could affect staff and up to 6 residents.<br><br>Findings include:<br><br>Based on observation with the Director of | K 0018 | **K018**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the* | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | Plant Operations and Administrator on 01/20/16 at 12:14 p.m., the corridor resident room door 427 was not smoke resistant due to a quarter inch hole drilled through. Based on interview at the time of observation, the Director of Plant Operations and Administrator acknowledged the aforementioned condition.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure 3 of 115 resident room corridor doors closed and latched into the door frame. This deficient practice could affect 3 residents.<br><br>Findings include:<br><br>Based on observation on 01/20/16 between 10:52 a.m. and 12:34 p.m., the following resident rooms failed to latch:<br>a) resident room 202<br>b) resident room 437<br>c) resident room 440<br>Based on interview at the time of each observation, the Director of Plant Operations and Administrator acknowledged the corridor doors failed to latch into the frame.<br><br>3.1-19(b)<br>3. Based on observation and interview, | | *center's credible allegation of compliance.*<br><br>*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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident room 427 hole in door was repaired. Resident rooms 202, 437, and 440 were repaired so that the doors latch. ADON office door stop was removed.<br><br>**2) How the facility identified other residents:**<br><br>All other doors were inspected for any holes. All other doors were inspected for whether they latch properly. All other doors were inspected for door stops. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | the facility failed to ensure 1 of 1 Assistant Director of Nursing room corridor doors closed and latched into the door frame. This deficient practice could affect staff only.<br><br>Findings include:<br><br>Based on observation on 01/20/16 at 4:11 p.m., the Assistant Director of Nursing office corridor door had a piece of plastic being used as a door stop that prevented the room door from closing and latching into the door frame.<br><br>3.1-19(b) | | **3) Measures put into place/ System changes:**<br><br>Every door in the building will be inspected monthly for holes, properly closing, and door stops by maintenance under the direction of the administrator. Any doors identified as having issues will be corrected.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:**<br><br>**02/19/16** | |
| K 0025<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4<br>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 ceiling barrier was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect staff and at least 8 residents.<br><br>Findings include:<br><br>Based on observations with the Director of Plant Operations and Administrator on 01/20/16 between 10:41 a.m. and 2:21 p.m., the following ceiling barriers contained penetrations: | K 0025 | **K025**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>**1) Immediate actions taken for those residents identified:** | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | a) one half inch ceiling penetration in LSR storage room<br>b) a three and a half inch ceiling penetration in the 300 Hall Dining room.<br>c) ten separate ceiling penetrations ranging from an eighth of an inch to four by five inch penetration in the 300 Hall Boiler Room.<br>d) a seven inch by one inch ceiling penetration in the 300 Hall Clean Linen room.<br>e) two separate two inch ceiling penetrations in the 200 Hall Biohazard room.<br>f) one and a half by two inch ceiling penetration in the Kitchen Break room.<br>Based on interview at the time of each observation, the Director of Plant Operations and Administrator acknowledge each aforementioned condition and provided the measurements.<br><br>3.1-19(b) | | Ceiling barrier penetrations were repaired in a) LSR storage room, b) 300 hall dining room, c) 300 hall boiler room, d) 300 hall clean linen room, e) 200 hall biohazard room, f) kitchen break room.<br><br>**2) How the facility identified other residents:**<br><br>Ceilings in other areas of the building were inspected for barrier penetrations.<br><br>**3) Measures put into place/ System changes:**<br><br>Ceilings will be inspected in 5 rooms per week for penetrations by Maintenance under the direction of the administrator. Any identified areas will be repaired.<br><br>**4) How the corrective actions will be monitored:** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | | | The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:**<br><br>**02/19/16** | |
| K 0027<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7<br>Based on observation, the facility failed to ensure 1 of 2 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close | K 0027 | **K027**<br><br>**The facility requests paper compliance for this citation.** | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | 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 could affect staff and 19 residents.<br><br>Findings include:<br><br>Based on observation with the Director of Plant Operations and Administrator on 01/20/16 at 10:51 a.m., the smoke barrier doors by resident room 201 failed to close completely when tested. One of the smoke barrier doors was caught up on the coordinator leaving a two inch gap between the doors. Based on interview at the time of observation, the Director of Plant Operations and Administrator acknowledged the aforementioned condition.<br><br>3.1-19(b) | | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>The smoke barrier doors by resident room 201 were repaired.<br><br>**2) How the facility identified other residents:**<br><br>All smoke barrier doors were tested to ensure that they close properly. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | | | **3) Measures put into place/ System changes:**<br><br>A monthly audit of smoke barrier doors will be done by maintenance under the direction of the administrator to ensure that they close properly. Any doors which do not close correctly will be repaired.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:**<br><br>**02/19/16** | |
| K 0029<br>SS=D<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 200 Hall Central Supply storage area greater than 50 square feet, a hazardous area, was smoke resistive when the door was closed. This deficient practice could affect staff and 9 residents<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor and Maintenance Assistant on 01/20/16 at 1:30 p.m., Room 224 was used for Central Storage. Many small cardboard boxes were stored in the room which was greater than 50 square feet. The door self closed and latch into the frame. When the door was closed, there was a half inch by fifty eight inch opening between the door and the frame. Based on interview at the time of observation, the Maintenance Supervisor and Maintenance Assistant acknowledged the aforementioned condition.<br><br>3.1-19(b) | K 0029 | **K029**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>The gap in the central supply door | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | 2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 400 Hall Mechanical room, 1 of 1 Kitchen, and 1 of 1 100 West Hall storage room, each a hazardous area, was provided with self closer and would latch into the frame. This deficient practice could affect facility staff.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor and Maintenance Assistant on 1/7/16 between 12:25 p.m. and 2:49 p.m., the following hazardous rooms failed to latch into the frame when tested:<br>a) 400 Hall Mechanical room which contained a fuel fire appliance<br>b) 1 of 4 Kitchen doors<br>c) 1 of 4 Kitchen doors did not contain a self-closer<br>d) 100 West Hall storage room greater than 50 square feet contained 8 mattress and 26 cardboard boxes office supplies did not contain a self-closer<br>Based on interview at the time of each observation, the Director of Plant Operations and Administrator acknowledged the aforementioned condition.<br><br>3.1-19(b) | | was repaired. The self-closer and self-latching was repaired on the 400 hall mechanical room. A self-closer and self-latching mechanism was installed on the kitchen door, and the 100 West hall storage.<br><br>**2) How the facility identified other residents:**<br><br>All other doors were tested to determine if there was a gap or issues with self-closing or latching.<br><br>**3) Measures put into place/ System changes:**<br><br>Maintenance under the direction of the administrator will audit 5 doors per week for the presence of a gap and if self-closer is present that it is operating correctly. All doors will be audited monthly by maintenance under the direction of the administrator to determine that they latch correctly. Any issues noted will be repaired.<br><br>**4) How the corrective actions will be monitored:** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | | | The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:**<br><br>**02/19/16** | |
| K 0038<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br>1. Based on observation and interview, the facility failed to ensure 1 of 3 200 Hall exit access corridors was readily accessible and unobstructed at all times. This deficient practice could affect staff and at least 9 residents.<br>Findings include:<br>Based on an observation with the Director of Plant Operations and Administrator on 01/20/16 at 1:27 p.m., the 200 Hall had storage in the hallway outside the Central Supply office. Thirteen large cardboard boxes and a large dolly were stacked near the door.<br>Based on an interview at the time of | K 0038 | **K038**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute* | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | observation, the Director of Plant Operations and Administrator acknowledged these items were being stored in the corridor and could not identify when the items were delivered nor when the boxes would be moved. 3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 delayed egress locks on the Employee West exit and Resident Smoking Area exit was readily accessible for residents, staff, and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 seconds nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an | | *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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>The boxes in the hall outside of the 200 exit were moved and put away. The egress exit to the Employee West exit and the Resident Smoking Exit was repaired so that the 15 second delay worked as designed. The exit walkway for the exterior exit door by room 432 will be repaired with a temporary walkway until a permanent cement walkway can be installed.<br><br>**2) How the facility identified other residents:**<br><br>All other halls were observed for the storage of boxes and none were noted. All other egress exits were tested to determine if they worked correctly. All other exits had cement walkways that were intact. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect staff and up to 8 residents.<br>Findings include:<br>Based on observation with the Director of Plant Operations and Administrator on 01/20/16 at 11:36 a.m. then again at 1:05 p.m., the West Employee exit door was equipped with a delayed egress lock, and is provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device. However, the exit door failed to open within 15 seconds when the door was pushed with the application of force. Then again the Resident Smoking Area exit was equipped with a delayed egress lock, and is provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device. However, the exit door failed to open within 15 seconds when the door was pushed with the application of force. Based on interview at the time of each observation, the acknowledged the aforementioned condition.<br>3.1-19(b)<br><br>3. Based on observation and interview, the facility failed to ensure exit access was arranged so 1 of 1 exits by room 432 | | **3) Measures put into place/ System changes:**<br><br>An audit will be done to three egress exits per week by maintenance under the direction of the administrator to determine if the doors work correctly with a 15 second delay where appropriate, that there are no items stored in the corridor, and that the cement walkway is intact.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:**<br><br>**02/19/16** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | were readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires the means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. In addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy periods of rain. This deficient practice could affects staff only.<br><br>Findings include:<br><br>Based on observation with the Director of Plant Operations and Administrator on 01/20/16 at 12:30 p.m., the exterior exit door by room 432 discharge contained cement except a fifty foot section that was removed for construction. Based on interview at the time observation, the Director of Plant Operations and Administrator acknowledged the | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | aforementioned condition and provided the measurement.<br><br>3.1-19(b) | | | |
| K 0044<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5<br>Based on observation and interview, the facility failed to ensure 5 of 9 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect staff and at least 21 residents.<br><br>Findings include:<br><br>Based on observation with the Director of Plant Operations and Administrator on 01/20/16 between 10:47 a.m. and 12:14 p.m., the following fire doors failed to | K 0044 | **K044**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.* | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | latch into the frame:<br>a) fire doors near the Maintenance office<br>b) fire doors between 200-300 Hall<br>c) fire doors in the 400 Hall Dining Room<br>d) fire doors near resident room 401<br>e) fire doors near resident room 422<br>Based on interview at the time of observation, the Director of Plant Operations and Administrator acknowledged the aforementioned conditions and confirmed each set of doors was fire doors.<br><br>3.1-19(b) | | **1) Immediate actions taken for those residents identified:**<br><br>The fire doors near the maintenance office, the doors between the 200-300 hall, the fire doors in the 400 dining hall, the fire doors near resident room 401, and the fire doors near resident room 422 were all repaired.<br><br>**2) How the facility identified other residents:**<br><br>All other fire and smoke doors were checked for proper closure.<br><br>**3) Measures put into place/ System changes:**<br><br>An audit will be completed to 5 sets of fire doors per week by maintenance under the direction of the administrator to determine if they close correctly. Any doors that are not working correctly will be repaired.<br><br>**4) How the corrective actions will be monitored:** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | | | The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:**<br><br>**02/19/16** | |
| K 0048<br>SS=C<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1<br>Based on record review, observation, and interview, the facility failed to provide a written plan that included the evacuation of smoke compartments in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:<br>(1) Use of alarms<br>(2) Transmission of alarm to the fire department<br>(3) Response to alarms<br>(4) Isolation of fire<br>(5) Evacuation of immediate area<br>(6) Evacuation of smoke compartment<br>(7) Preparation of floors and building for | K 0048 | **K048**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the* | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | evacuation<br>(8) Extinguishment of fire<br>This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on a record review with the Director of Plant Operations and Administrator on 01/20/16 at 1:43 p.m., the facility had a written fire policy that horizontal evacuation would be performed by crossing a smoke barrier. However, there were corridor doors that were not complete smoke or fire barriers which could cause staff to evacuate residents to a different part of the same smoke compartment and not to an adjacent compartment in the event of a fire. Based on interview at each observation, there were five sets of doors (by resident rooms 440, 432, 313, doors between 300/400 halls, 200 Dining Hall) that the Director of Plant Operations confirmed were not complete smoke or fire barriers. The Director of Plant Operations and Administrator acknowledged the aforementioned condition.<br><br>3.1-19(b) | | *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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>. The written fire plan was updated to reflect where to take residents in the event of a horizontal evacuation so that they are taken to a different smoke compartment.<br><br>**2) How the facility identified other residents:**<br><br>. The fire plan affects all units in the facility.<br><br>**3) Measures put into place/ System changes:**<br><br>An in-service was completed for staff in all departments to explain the new horizontal evacuation policy. An audit will be done by maintenance under the direction of the administrator on 5 employees per week to determine understanding of the smoke compartments. The audit will be done on employees from a | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | | | variety of departments, on all shifts, and different days.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:**<br><br>**02/19/16** | |
| K 0051<br>SS=D<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6<br>Based on observation and interview, the facility failed to ensure 1 of 1 smoke detector in the 100 Hall Common area was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff and at least 1 resident. Findings include:<br>Based on observation with the Director of Plant Operations and Administrator on 01/20/16 at 2:41 p.m., the 100 Hall Common area had a smoke detector located twenty inches away from an HVAC vent. Based on interview at the time of observation, the Director of Plant Operations and Administrator acknowledged the aforementioned condition and provided the measurement. 3.1-19(b) | K 0051 | **K051**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>The smoke detector in the 100 hall was moved to be a sufficient distance from the HVAC vent. | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | | | **2) How the facility identified other residents:**<br><br>. All other smoke detectors were observed to determine if any were not located a sufficient distance from an HVAC vent. Any identified detectors were moved.<br><br>**3) Measures put into place/ System changes:**<br><br>An audit will be done by maintenance, under the direction of the administrator, of one hall per week to determine if the smoke detectors are located a sufficient distance from an HVAC vent. Any detectors determined to be too close will be moved.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | | | **5) Date of compliance:**<br><br>**02/19/16** | |
| K 0056<br>SS=D<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5<br>Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two | K 0056 | **K056**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.* | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.<br>Findings include:<br>Based on observation with the Director of Plant Operations and Administrator on 01/20/16 at 2:00 p.m., there were no sidewall sprinklers in the spare sprinkler cabinet. Based on observation during the tour, there was a sidewall sprinkler head located on the exterior wall of all the exit discharges. Based on interview at the time of each observation, the Director of Plant Operations and Administrator acknowledged the aforementioned conditions.<br>3.1-19(b) | | *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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Two sidewall sprinkler heads were purchased and placed in the spare sprinkler cabinet.<br><br>**2) How the facility identified other residents:**<br><br>.All other types of sprinkler heads were identified.<br><br>**3) Measures put into place/ System changes:**<br><br>An audit will be done weekly by maintenance under the direction of the administrator to determine which types of sprinkler heads should be in the cabinet and if there are at least two of them. If there are any sprinkler heads missing or used from the cabinet, they will be replaced. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | | | **4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:**<br><br>**02/19/16** | |
| K 0062<br>SS=F<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5<br>1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be | K 0062 | **K062**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the* | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all occupants in the facility including staff, visitors and residents.<br><br>Findings include:<br><br>Based on review of sprinkler system documentation with the Director of Plant Operations and Administrator on 01/20/16 at 9:41 a.m., none of the quarterly sprinkler system inspection and testing records indicated an internal inspection of the sprinkler system pipes had been conducted. Based on interview at the time of record review, the Director of Plant Operations and Administrator acknowledged the aforementioned condition.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition | | *center's credible allegation of compliance.*<br><br>*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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>a) A five year internal inspection of the automatic sprinkler piping system will be completed.<br><br>b) The gage was replaced in the regional business office.<br><br>c) The corroded sprinkler heads outside the front entrance, in the mechanical room, in the laundry soiled lined room, in the boiler room, in the dish room, in the walk in freezer will be repaired.<br><br>d) The sprinkler head in the 100 hall common area will be repaired.<br><br>**2) How the facility identified other** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents.<br><br>Findings include:<br><br>Based on observation with the Director of Plant Operations and Administrator on 01/20/16 at 10:39 a.m., the sprinkler pipe located in the Regional Business Office had one gauge installed. The gauge indicated it was manufactured in 2003. Based on interview at the time of observation, the Director of Plant Operations and Administrator acknowledged the aforementioned condition.<br><br>3.1-19(b)<br><br>3. Based on observation and interview, the facility failed to replace painted or covered sprinkler heads in the Front Office, Mechanical Room, Laundry Room, Boiler Room, Dish Room, and Walk-in-Freezer. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all | | **residents:**<br><br>Other gages will be assessed to determine if they have been evaluated in the past five years. All sprinkler heads will be assessed to determine if there are any additional ones that are corroded.<br><br>**3) Measures put into place/ System changes:**<br><br>An audit will be completed on one hall each week by maintenance under the direction of the administrator to determine if there are any corroded sprinklers, soiled sprinklers, or escutcheons missing. Any issues will be corrected.<br><br>An audit will be done on one hall per week by maintenance under the direction of the administrator to determine if there are any gages that have not had a five year inspection. Any issues identified will be corrected.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in Quality Assurance | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff only.<br><br>Findings include:<br><br>Based on observation with the Director of Plant Operations and Administrator on 01/20/16 between 10:31 a.m. and 2:23 p.m., the following sprinkler heads were corroded:<br>a) 9 of 9 sprinkler heads outside the Front Entrance<br>b) 2 of 2 sprinkler heads in the Mechanical Room<br>c) 4 of 4 sprinkler heads in the Laundry Soiled Linen Room<br>d) 1 of 6 sprinkler heads was covered in dirt and lint in the Boiler Room<br>e) 6 of 6 sprinkler heads in the Dish Room<br>f) 2 of 2 sprinkler heads in the Walk-in-Freezer<br>Based on interview at the time of observation, the Maintenance Supervisor and Director of Nursing acknowledged the aforementioned condition. | | Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:**<br><br>**02/19/16** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | 3.1-19(b)<br><br>4. Based on observation and interview, the facility failed to ensure 1 of 3 sprinkler heads in the 100 Hall common area by nurse's station was maintained. This deficient practice could affect staff and at least 2 residents.<br><br>Findings include:<br><br>Based on observations the Director of Plant Operations and Administrator on 01/20/16 at 2:40 p.m., the 100 Hall Common area by the nurse's station was missing one escutcheon. Based on interview at the time of observation, the Director of Plant Operations and Administrator acknowledged the missing escutcheon at the time of observation.<br><br>3.1-19(b) | | | |
| K 0066 SS=D Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Smoking regulations are adopted and include no less than the following provisions:<br><br>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | NO SMOKING or with the international symbol for no smoking.<br><br>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.<br><br>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.<br><br>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4<br>Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container with a self-closing lid at 1 of 1 outside areas of this smoke-free facility. This deficient practice could affect staff only.<br>Findings include:<br><br>Based on observations with the Director of Plant Operations and Administrator on 01/20/16 at 12:30 p.m., there were at least 20 cigarette butts commingled with trash in the plastic trash can outside the employee entrance. Based on interview at the time of observation, the Director of Plant Operations and Administrator acknowledged the aforementioned condition.<br><br>3.1-19(b) | K 0066 | **K066**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.* | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | | | **1) Immediate actions taken for those residents identified:**<br><br>The trash can was emptied.<br><br>**2) How the facility identified other residents:**<br><br>All other trash cans were checked and emptied.<br><br>**3) Measures put into place/ System changes:**<br><br>Staff in all departments will be in-serviced on not placing cigarette butts in the exterior trash cans.<br><br>All exterior trash cans will be audited weekly by housekeeping under the direction of the administrator for the presence of cigarette butts. If found, they will be emptied and the administrator notified.<br><br>**4) How the corrective actions will be monitored:** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | | | The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:**<br><br>**02/19/16** | |
| K 0072<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10<br>Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency for 2 of 11 exit discharge paths. This deficient practice could affect staff and at least 7 residents.<br><br>Findings include:<br><br>Based on observation with the Director of Plant Operations and Administrator on 01/20/16 at 12:05 p.m. then again at 3:01 | K 0072 | **K072**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.* | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | p.m., the 400 East Hall exterior exit path of egress was obstructed by a very large trash dumpster. Then again the 100 Hall courtyard exit discharge contained one and a half inch accumulation of snow. Based on interview at the time of each observation, the Director of Plant Operations and Administrator acknowledged the aforementioned conditions.<br><br>3.1-19(b) | | *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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>The snow was removed, and the dumpster was moved.<br><br>**2) How the facility identified other residents:**<br><br>All other paths of egress were checked.<br><br>**3) Measures put into place/ System changes:**<br><br>An audit of three exits per week will be done by maintenance under the direction of the administrator to determine if there is any snow, debris, or other items blocking the path of egress. Any issues identified will be corrected. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | | | **4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:**<br><br>**02/19/16** | |
| K 0076<br>SS=D<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.<br><br>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.<br><br>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside.<br>NFPA 99 4.3.1.1.2, 19.3.2.4<br>Based on observation and interview, the facility failed to ensure 1 of 1 electrical outlets in the oxygen transfilling room in the 200 Hall and 400 Hall was located at least five feet above the floor. NFPA 99, | K 0076 | **K076**<br><br>**The facility requests paper** | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice could affect staff only.<br><br>Findings include:<br><br>Based on observation with the Director of Plant Operations and Administrator on 01/20/16 at 11:01 a.m. then again at 11:49 a.m., there is one electrical outlet on the wall in the 200 Hall oxygen transfilling room forty five inches off the ground. Then again there is one electrical outlet on the wall in the 400 Hall oxygen transfilling room forty two inches off the ground. Based on interview at the time of each observation, the Director of Plant Operations and Administrator acknowledged each aforementioned condition.<br><br>3.1-19(b) | | **compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>The electrical switches in the 200 and the 400 oxygen transfilling rooms were removed.<br><br>**2) How the facility identified other residents:**<br><br>There are no other oxygen transfilling rooms in the building. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | | | **3) Measures put into place/ System changes:**<br><br>Audit will be done weekly by maintenance under the direction of the administrator to ensure that an outlet is not reinstalled in the transfilling room.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:**<br><br>**02/19/16** | |
| K 0130<br>SS=E<br>Bldg. 01 | NFPA 101<br>MISCELLANEOUS<br>OTHER LSC DEFICIENCY NOT ON 2786<br>1. Based on observation and interview, the facility failed to ensure the penetration in 6 of 9 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 | K 0130 | **K130**<br><br>**The facility requests paper** | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:<br>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:<br>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.<br>b. It shall be protected by an approved device that is designed for the specific purpose.<br>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:<br>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.<br>b. It shall be protected by an approved device that is designed for the specific purpose.<br>This deficient practice could affect 33 residents.<br><br>Findings include: | | **compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>The attic fire wall penetrations were corrected in a) the 200 Hall Dining fire barrier, b) the fire wall near resident room 119, c) the fire wall near resident room 233, d) the 400 Dining fire wall, e) the fire barrier near resident room 401, f) the fire wall near resident room 422.<br><br>The fire barrier door by the maintenance office will be replaced with a 90 minute door. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | Based on an observation with the Maintenance Supervisor on 11/16/15 between 3:32 p.m. and 4:10 p.m., the following attic fire wall penetrations were discovered:<br>a) two separate two inch gap inside conduit was not sealed in the 200 Hall Dining fire barrier. Additionally, a two inch unsealed penetration and one penetration sealed with an expandable foam.<br>b) an eight inch by ten inch brick was removed from the fire wall near resident room 119.<br>c) a half inch gap inside conduit was not sealed in the fire wall near resident room 233.<br>d) five separate penetrations was sealed with expandable foam in the 400 Dining fire wall.<br>e) a quarter inch gap around conduit was not sealed in the fire barrier near resident room 401.<br>f) five separate penetrations were sealed with expandable foam in the fire wall near resident room 422. Additionally, a one inch unsealed penetration around sprinkler line and a three foot by four foot piece of drywall was removed and leaning up against the fire wall.<br>Based on interview at the time of each observation, the Director of Plant Operations was unable to provide | | **2) How the facility identified other residents:**<br><br>Other areas were assessed for fire wall penetrations and properly rated fire doors.<br><br>**3) Measures put into place/ System changes:**<br><br>An audit will be done of one fire wall per week by maintenance under the direction of the administrator to determine if there are any penetrations and the doors are rated for the proper length of time. Any issues will be corrected.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | documentation for the expandable foam product used in the fire wall. The Director of Plant Operations acknowledged each aforementioned condition and provided the measurements.<br><br>3.1-19(b)<br><br>2. Based on record review, interview, and observation, the facility failed to install a 1.5 hour door in accordance to LSC 101 8.2.3.2.3.1. Section 8.2.3.2.3.1 states every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protectives (1) 2 hour fire barrier -- 1 1/2 hour fire protection rating. This deficient practice could affect staff, visitors, and at least 8 residents plus residents in the 200 Hall Dining Room.<br><br>Findings include:<br><br>Based on interview and record review with the Director of Plant Operations and Administrator on 01/20/16 during record review between 10:11 a.m. and 10:24 a.m., the Director of Plant Operations indicated where the smoke and fire barriers were. Based on observation with the Director of Plant Operations and | | **02/19/16** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | Administrator at 10:47 a.m., the fire barrier by the Maintenance Office door contained latching hardware but was rated for 30 minutes. The Director of Plant Operations and Administrator acknowledged the aforementioned condition.<br><br>3.1-19(b) | | | |
| K 0144<br>SS=C<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.<br>Based on record review and interview, the facility failed to ensure a written record of weekly inspections of the generator was maintained for 5 of 52 weeks. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review of generator documentation with the Director of Plant Operations and Administrator on | K 0144 | **K144**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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* | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | 01/20/16 at 10:21 a.m., the weekly generator inspections were not documented after 12/15/15. Based on interview at the time of record review, the Director of Plant Operations and Administrator acknowledged the aforementioned condition.<br><br>3.1-19(b) | | *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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>The generator documentation for the current week was completed. Maintenance Director was in-serviced 1:1 on the need for weekly documentation of the generator.<br><br>**2) How the facility identified other residents:**<br><br>All areas of the facility could be affected by generator issues.<br><br>**3) Measures put into place/ System changes:**<br><br>An audit will be done by the administrator or designee weekly to determine if the generator inspections/ documentation was done. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | | | **4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:**<br><br>**02/19/16** | |
| K 0147<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br>1. Based on observation and interview, the facility failed to ensure 1 of 1 electrical junction boxes in the ceiling in 200 Hall observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice | K 0147 | **K147**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.* | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | could affect staff and up to 9 residents.<br><br>Findings include:<br><br>Based on observation with the Director of Plant Operations and Administrator on 01/20/16 at 1:25 p.m., there was exposed wiring in a junction box without a cover in corridor ceiling outside of resident room 220. Based on interview at the time of observation, the Director of Plant Operations and Administrator acknowledged the aforementioned condition.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure 1 of 1 multiplug adapters and 14 of 14 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and at least 4 residents.<br><br>Findings include:<br><br>Based on observation with Maintenance | | *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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>A plate was placed over the exposed wiring in the junction box outside of resident room 220.<br><br>The power strip in the front office was removed, the multiplug adapter was removed from room 207, the high current draw items were removed from the surge protectors in the Social Services office, the therapy office, the ADON office, the Activities office, The DON office, The Care Plan office, the Medical Records office, and the resident room 101.<br><br>The surge protectors and extension cords were removed from the boiler room. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | Director on 07/20/15 between 10:34 a.m. to 2:53 p.m. the following was discovered:<br>a) a power strip was powering a refrigerator and a microwave in the Front Office<br>b) a multiplug adapter was powering a television and a clock in resident room 207<br>c) a surge protector powering a refrigerator in resident room 303<br>d) a surge protector powering a microwave in the Social Services office.<br>e) a surge protector powering a microwave and a refrigerator in the Therapy office.<br>f) a surge protector powering a refrigerator in the Assistant Director of Nursing office.<br>g) a surge protector powering a coffee pot in the Activities office.<br>h) a surge protector powering a refrigerator in the Director of Nursing office.<br>i) a surge protector powering a dehumidifier in the Care Plan office.<br>j) a surge protector powering a microwave, refrigerator, and a coffee pot in the Medical Record office.<br>k) a surge protector powering another surge protector powering an extension cord powering a fan in the 200 Hall Boiler Room. Additionally, there was also an extension cord powering a water | | The outlet cover was replaced in the 400 Hall Common Area.<br><br>**2) How the facility identified other residents:**<br><br>The remaining junction boxes in the facility were checked for exposed wiring.<br><br>The remaining rooms of the facility were checked for appropriate use of surge protectors.<br><br>The other areas of the facility were checked for outlets missing outlet covers.<br><br>**3) Measures put into place/ System changes:**<br><br>An audit will be done by maintenance under the direction of the administrator for one hall per week to determine if any junction boxes contain exposed wiring. Any issues will be corrected.<br><br>An audit will be done by maintenance under the direction of the administrator on 5 rooms per week for the proper use of surge protectors. Any issues noted will be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | softener.<br>l) a surge protector powering a refrigerator in resident room 101<br>Based on interview at the time of observation, the Director of Plant Operations and Administrator acknowledged each aforementioned condition.<br><br>3.1-19(b)<br><br>3. Based on observation and interview, the facility failed to maintain an electrical outlet in 1 of 1 400 Hall Commons area. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff only.<br><br>Findings include:<br><br>Based on observations with the Director of Plant Operations and Administrator on 01/20/16 at 12:02 a.m., the 400 Hall Commons area contained an outlet without an outlet cover. Based on interview at the time of observation, the Director of Plant Operations and Administrator acknowledged the aforementioned condition.<br><br>3.1-19(b) | | corrected.<br><br>An audit of 5 rooms/ areas per week will be done by maintenance under the direction of the administrator to determine if there are any missing outlet covers. Any issues will be corrected.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:**<br><br>**02/19/16** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| K 0154<br>SS=C<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1<br>Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 in order to protect 114 of 114 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, A-11-5(c) 2 states, "a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are | K 0154 | **K154**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.* | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | available and functioning properly." This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review of the "Emergency Fire Watch" on 01/20/16 at 1:42 p.m., the facility's documentation provided for a plan of action when the sprinkler system was out of service for more than four hours in a twenty four hour period but was not complete. The procedure did not include all elements required such as; the person conducting the fire watch shall be trained and the person conducting the fire watch shall have no other duties during that time. Based on an interview record review, the Director of Plant Operations and Administrator acknowledged the aforementioned condition.<br><br>3.1-19(b) | | **1) Immediate actions taken for those residents identified:**<br><br>The policy for Fire Watch was updated to include the information that the person would be trained and would have no additional duties while on fire watch.<br><br>**2) How the facility identified other residents:**<br><br>All areas of the building could be affected by fire watch.<br><br>**3) Measures put into place/ System changes:**<br><br>Staff in all departments were in-serviced on Fire Watch policy.<br><br>An audit will be done of 5 employees weekly by maintenance under the direction of the administrator to determine that they are able to identify the Fire Watch policy. Audits will be done on employees in a variety of departments, on various shifts, and various days.<br><br>**4) How the corrective actions will be monitored:** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | | | The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:**<br><br>**02/19/16** | |
| K 0155<br>SS=C<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8<br>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 114 of 114 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the | K 0155 | **K155**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.* | 02/19/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affects all occupants.<br><br>Findings include:<br><br>Based on record review of the "Emergency Fire Watch" on 01/20/16 at 1:42 p.m., the facility's documentation provided for a plan of action when the fire alarm system was out of service for more than four hours in a twenty four hour period but was not complete. The procedure did not include all elements required such as; the person conducting the fire watch shall be trained and the person conducting the fire watch shall have no other duties during that time. Based on an interview record review, the Director of Plant Operations and Administrator acknowledged the aforementioned condition. | | *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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>The policy for Fire Watch was updated to include the information that the person would be trained and would have no additional duties while on fire watch.<br><br>**2) How the facility identified other residents:**<br><br>All areas of the building could be affected by fire watch.<br><br>**3) Measures put into place/ System changes:**<br><br>Staff in all departments were in-serviced on Fire Watch policy. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155156 | A. BUILDING 01<br>B. WING | 01/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBORS AT MICHIGAN CITY | 1101 E COOLSPRING AVE<br>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 |
|---|---|---|---|---|
| | 3.1-19(b) | | An audit will be done of 5 employees weekly by maintenance under the direction of the administrator to determine that they are able to identify the Fire Watch policy. Audits will be done on employees in a variety of departments, on various shifts, and various days.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3<br><br>months, then quarterly x1 for a total of 6 months.<br><br>**5) Date of compliance:**<br><br>**02/19/16** | |