STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 01 B. WING	03/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 01/20/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/04/16 Facility Number: 000076 Provider Number: 155156 AIM Number: 100271060 At this PSR survey, Arbors at Michigan City was found in substantial 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. 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	K 0000		

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

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	a capacity of 180 and had a census of 113 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/07/16 - DA			
K 0025 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may 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 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	K 0025	**K025** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	03/14/2016

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	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 only. Findings include: Based on observations with the Maintenance Director on 03/04/16 at 11:15 a.m. then again at 1:18 a.m., two separate two inch ceiling penetrations in the 200 Hall Biohazard room. Then again, one half inch ceiling penetration in CSR storage room. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition and provided the measurements. 3.1-19(b) This deficiency was cited on 01/20/16. The facility failed to implement a systemic plan of correction to prevent recurrence.		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Ceiling barrier penetrations were repaired in a) 200 hall biohazard room and b) CSR storage room. **2) How the facility identified other residents:** Ceilings in other areas of the building were inspected for barrier penetrations. **3) Measures put into place/ System changes:**	

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			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. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** **03/14/16**	
K 0029 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 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 approved automatic fire extinguishing			

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	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 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Kitchen, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director on 03/04/16 at 9:33 a.m., one of four Kitchen doors failed to latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b) This deficiency was cited on 01/20/16. The facility failed to implement a systemic plan of correction to prevent recurrence.	K 0029	**K029** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The kitchen door was repaired so that it latched in the frame.	03/14/2016

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			2) How the facility identified other residents: All other doors were tested to determine if there was a gap or issues with self-closing or latching. **3) Measures put into place/ System changes:** 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. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3	

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			months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** **03/14/16**	