STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155156	A. BUILDING -- B. WING	02/01/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	. An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/01/18 Facility Number: 000076 Provider Number: 155156 AIM Number: 100271060 At this Emergency Preparedness survey, Aperion Care Arbors of Michigan City was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 180 certified beds. At the time of the survey, the census was 121. Quality Review completed on 02/08/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0024 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR	E 0024	**The facility requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation	02/28/2018

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

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	483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based on record review with the Executive Director and the Maintenance Director on 02/01/18 between 10:00 a.m. and 11:05 a.m., no policies and procedures that included the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. Based on interview at the time of record review, the Executive Director and the Maintenance Director confirmed no documentation was available for review.		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 emergency and Disaster preparedness manual now includes instructions for visitors and volunteers **2) How the facility identified other residents:** All residents would have been affected if an emergency had occurred during this period.	

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			3) Measures put into place/ System changes: The instruction sheet has been added to the manual and managers were inserviced. **4) How the corrective actions will be monitored:** The procedure for visitors and Volunteers will be practiced during the tabletop and county emergency practice set up by CHUG and the Laporte county emergency management office . The results of these practice will be reviewed at the monthly Quality Assurance Meeting	
E 0026 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate	E 0026	**The facility requests paper compliance for this citation.** This Plan of Correction is the	02/28/2018

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	care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8). This deficient practice could affect all occupants. Findings include: Based on record review with the Executive Director and the Maintenance Director on 02/01/18 between 10:00 a.m. and 11:05 a.m., the emergency preparedness plan failed to include a policy and procedure for the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act. Based on interview at the time of record review, the Executive Director and the Maintenance Director confirmed no documentation was available for review.		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:** Risk assessments of the facility are included in the Emergency/Disaster preparedness Manual as well as community resources and contact information with detailed plans regarding the identified risk of the area and the arbors building specifically (Kaiser report, narrative report and CMS facility assessment tool **2) How the facility identified other residents:** All residents would have been affected if an emergency had	

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			occurred **3) Measures put into place/ System changes:** Managers were inserviced on added documentation to the manual **4) How the corrective actions will be monitored** The facility assessment tool will be reviewed in monthly Quality Assurance Meeting monthly for any updated regulations **5) Date of compliance:**	
E 0035 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants. Findings include:	E 0035	**The facility requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation of compliance.	02/28/2018

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	Based on record review with the Executive Director and the Maintenance Director on 02/01/18 between 10:00 a.m. and 11:05 a.m., the emergency preparedness communication plan failed to include a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). Based on interview at the time of record review, the Executive Director and the Maintenance Director confirmed no other documentation was available for review.		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:** A letter was sent to residents, POAs, Guardians and families providing information regarding the Emergency and Disaster Preparedness of the Arbors building on 2/19/2018 and mailed to identified parties on 2/23/2018. See exhibit **2) How the facility identified other residents:** All resident could have been affected if an emergency occurred **3) Measures put into place/ System changes:** An annual letter will be provided to	

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			aforementioned recipients and the letter will be included in admission packet for future residents. This communication regarding the identified issue will be part of the marketing communication plan. **4) How the corrective actions will be monitored:** Marketing will report monthly at QA meeting x 6 months, continued communication.	
E 0036 SS=C Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on record review with the Executive Director and the Maintenance Director on 02/01/18 between 10:00 a.m. and 11:05 a.m., no training and testing portion of emergency preparedness has been created nor practiced. Based on interview at the time of record review, the Executive Director and the Maintenance Director confirmed no documentation was available for review.	E 0036	**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	02/28/2018

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			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:** A table top training exercise was conducted on 2/20/2018 at 9:15am. The scenario was a tornado hitting the community, lateral evacuation, disposable resource needs and community resource activation as well as communication strategies. **2) How the facility identified other residents:** All residents would have been affected if an emergency had occurred **3) Measures put into place/ System changes:** Procedure was practiced during a tabletop and county emergency practice with CHUG and the Laporte County Emergency Management Office	

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E 0039 SS=C Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2).	E 0039	**4) How the corrective actions will be monitored:** Results of tabletop practices will be brought to monthly QA meeting and reviewed. X 6months **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:**	02/28/2018

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	This deficient practice could affect all occupants. Findings include: Based on record review with the Executive Director and the Maintenance Director on 02/01/18 between 10:00 a.m. and 11:05 a.m., the facility did drills but the facility's emergency preparedness was not engaged. Based on interview at the time of record review, the Executive Director and the Maintenance Director confirmed the facility's emergency preparedness plan was not used in the drills.		A table top exercise was performed on 2/20/2018. The exercise scenario was a tornado hitting the community. A county wide disaster is scheduled for the summer of 2018. Until that time, tabletop exercises will continue. **2) How the facility identified other residents:** All residents would have been affected if emergency had occurred **3) Measures put into place/ System changes:** The Arbors will participate in the Laporte County Emergency practice drill schedule for 2018 **4) How the corrective actions will be monitored:** The results of these tabletop exercises will be reviewed in Quality Assurance Meeting monthly for 6 months	
K 0000 Bldg. 01				

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	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/01/18 Facility Number: 000076 Provider Number: 155156 AIM Number: 100271060 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 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 180 and had a census of 121 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 02/08/18 - DA	K 0000		
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that			

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	requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by			

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	an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 18 exits were readily accessible for residents. This deficient practice could affect staff and up to 34 residents. Findings include: Based on observation with the Executive Director and the Maintenance Director on 02/01/18 at 2:00 p.m., the Maintenance Director was unable to open the exit door next to the Business office. Based on interview at the time of the observation, the Executive Director and the Maintenance Director confirmed the door would not open. 3.1-19(b) 2. The facility failed to ensure the delayed egress locking arrangements were installed in accordance	K 0222	**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	02/28/2018

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	with 7.2.1.6.1(3) in 1 of 1 Front Entrance delayed egress locks. LSC 7.2.1.6.1(3) states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the 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 12 residents. Findings include: Based on observation with Executive Director and the Maintenance Director on 02/01/18 at 11:22 a.m., the Front Entrance exit door contained a 15 second delay device with a wander guard system. When tested, the magnetic control failed to release after 15 seconds. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged the aforementioned condition and confirmed the door failed to release in 15 seconds. 3.1-19(b)		required by the provisions of federal and state law. **1) Immediate actions taken for those residents identified:** The Magnetic locking mechanism near the business office has been replaced and is working properly **2) How the facility identified other residents:** No residents were affected **3) Measures put into place/ System changes:** Maintenance personnel will check mechanism monthly and add this task to monthly maintenance logs. **4) How the corrective actions will be monitored** Maintenance Director will bring results to QAA meeting for 6 months and quarterly thereafter if 100% complaint:	

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K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of 9 sets of smoke barrier doors had no impediments to self-close. This deficient practice could affect staff and at least 34 residents. Findings include: Based on record review with the Executive Director and the Maintenance Director on 02/01/18 at 11:40 a.m., the 200 Hall smoke barrier doors had a table with wheels in the path of one of the doors. Based on interview at the time of observation, the Executive Director and the Maintenance Director confirmed that the table with wheels is impeding the doors from fully closing. 3.1-19(b)	K 0223	**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	02/28/2018

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	155156	A. BUILDING 01 B. WING	02/01/2018

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			federal and state law. **1) Immediate actions taken for those residents identified:** The table was removed by the fire door **2) How the facility identified other residents:** All residents on that unit could have been affected by an obstructed fire door **3) Measures put into place/ System changes:** Staff were inserviced on not obstructing a fire door. Unit managers /maintenance director will check fire doors weekly for any obstruction. **4) How the corrective actions will be monitored** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	

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K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to ensure projections into 1 of 6 corridors met modifications allowed by 19.2.3.4 LSC 19.2.3.4(4)(c) allows equipment in use and carts in use as long as they are equipped with wheels when stored in the corridor. This deficient practice could affect staff and at least 34 residents in the smoke compartment. Findings include: Based on observation with the Executive Director and the Maintenance Director on 02/01/18 at 11:44 a.m., an isolation cart was in the corridor outside resident room 211. The cart was not provided with wheels. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged the isolation cart did not have wheels to move the cart out of the corridor in an emergency. 3.1-19(b)	K 0232	**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:**	02/28/2018

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			The non wheeled cart outside of Room 211 was replaced with a wheeled cart **2) How the facility identified other residents:** No resident was affected **3) Measures put into place/ System changes:** Maintenance will audit monthly for any non wheeled carts or hallway obstructions. Staff was re inserviced on having halls non obstructed **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure			

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	Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to maintain protection of 1 of 1 Laundry, 1 of 1 300 Hall Boiler room, 1 of 1 Storage room 324, 1 of 1 Storage Training room in accordance of 19.3.2. LSC 19.3.2, Protection from Hazards, requires doors to be self-closing or automatic closing. This deficient practice could affect staff and up to 61 residents.	K 0321	**The facility requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation of compliance.	02/28/2018

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	Findings include: Based on observation with the Executive Director and the Maintenance Director on 02/01/18 between 12:40 p.m. and 1:58 p.m., the following was discovered: a) the Laundry room contained fuel-fired equipment. The Laundry room contained three penetrations ranging from one inch to two and a half inches b) the 300 Hall Boiler room contained fuel-fired equipment. The 300 Hall Boiler room contained a two inch by six inch penetration c) Room 324 contained six television boxes, fifteen dresser boxes with dressers, and other miscellaneous storage. The corridor door did not have a self-closing device installed d) the Training Room contained at least ten artificial Christmas trees, cardboard boxes, and other miscellaneous storage. The corridor door did not have a self-closing device installed Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged each aforementioned areas were not protected by smoke resistive partitions and self-closing doors. 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. **1) Immediate actions taken for those residents identified:** The 3 penetrations in the laundry room, the penetration in the 300 boiler room have been sealed. The stored items in room 324 have been removed. The stored items in the training room have been removed. **2) How the facility identified other residents:** No residents were affected **3) Measures put into place/ System changes:**	

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			Maintenance was inserviced on the regulation regarding Hazardous areas. Maintenance/designee will provide a monthly audit on these areas **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure materials used as an interior finish on 1 of 1 Speech Therapy and 1 of 1 Memory Care sitting area had a flame spread rating of Class A or Class B in accordance with 19.3.3.1. LSC 101	K 0331	**The facility requests paper compliance for this citation.**	02/28/2018

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	10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method For Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect staff and up to 60 resident. Findings include: Based on observation with the Executive Director and the Maintenance Director on 02/01/18 at 12:33 p.m. then again at 1:38 p.m., the Speech Therapy area contained carpet on the walls. Then again, the Memory Care sitting area contained wood on the ceiling. Based on interview at the time of each observation, the Executive Director and the Maintenance Director was unable to provide interior finish documentation for a flame spread classification of Class A or B.		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 carpet on the wall of the speech room has been removed. The ceiling of the memory care sitting area has a fire rating coating in place **2) How the facility identified other residents:** No residents were affected **3) Measures put into place/ System changes:**	

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	3.1-19(b)		Maintenance department was inserviced of the correct practice. Housekeeping will audit monthly for non conformance to the regulation. **4) How the corrective actions will be monitored** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of 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 twenty four hour period in accordance with LSC, Section 9.6.1.6. This	K 0346	**The facility requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation	02/28/2018

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	deficient practice affects all occupants. Findings include: Based on record review with the Executive Director and the Maintenance Director on 02/01/18 at 11:39 a.m., the facility provided fire watch documentation but it was incomplete. The plan failed to include contacting the insurance company or the Indiana State Department of Health via the Web Portal. Based on an interview record review, the Executive Director and the Maintenance Director acknowledged fire watch policy failed to include contacting the insurance company and the web link for contacting the Incident Reporting System located on the Indiana State Department of Health (ISDH) Gateway. 3.1-19(b)		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 Indiana State department of health has been notified of the fire watch. **2) How the facility identified other residents:** No residents were affected **3) Measures put into place/ System changes:** The executive director was inserviced on the fire watch regulation and who to	

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			communicate the reporting of the fire watch to ISDH and corporate compliance. Weekly audits will be done to notify the appropriate departments if a fire watch should occur. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			

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	1. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all 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, 2011 edition, 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect all occupants. Findings include: Based on record review with the Executive Director and the Maintenance Director on 02/01/18 at 3:57 p.m., the 100 Hall attic contained a shop light tied to the sprinkler pipe. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged the aforementioned condition and confirmed the light was being strung along the sprinkler pipe. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all 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, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. This deficient practice could affect all occupants. Findings include:	K 0353	**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 shop light was removed from the 100 hall attic. All other attics were checked for lights. And sprinkler valves were checked **2) How the facility identified other residents:** No residents were affected by this practice	02/28/2018

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	Based on record review with the Executive Director and the Maintenance Director on 02/01/18 at 9:03 a.m., no documentation was available for the weekly dry system gauge and monthly wet system gauge inspection for August and September of 2017. Additionally, no documentation was available for monthly inspection of control valves. Based on interview at the time of record review, the Executive Director and the Maintenance Director acknowledged the lack of documentation. 3.1-19(b)		**3) Measures put into place/ System changes:** The maintenance department was in serviced. Quarterly maintenance checks of the attic areas for compliance and checked after each outside vendor enters the attic area. Audits will be added for the weekly dry system abd monthly for the wet system. Audit of monthly inspection of the control valves **4.) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where			

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	the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of 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 twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on record review with the Executive Director and the Maintenance Director on 02/01/18 at 11:39 a.m., the facility provided fire watch documentation but it was incomplete. The plan failed to include contacting the insurance company or the Indiana State Department of Health via the Web Portal. Based on an interview record review, the Executive Director and the Maintenance Director acknowledged fire watch policy failed to include contacting the insurance company and the web link for contacting the Incident Reporting System located on the Indiana State Department of Health (ISDH) Gateway. 3.1-19(b)	K 0354	**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 ISDH of notified of the Fire watch.	02/28/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			2) How the facility identified other residents: No residents were affected **3) Measures put into place/ System changes:** The Executive Director will be inserviced regarding the regulation of Fire Watch. The Executive Director will inservice the maintenance department. Any disruption of 4 hours or longer will be audited and the regulation adhered following with proper notification. **4.) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	
K 0363 SS=E	NFPA 101 Corridor - Doors			

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	155156	A. BUILDING 01 B. WING	02/01/2018

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Bldg. 01	Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing			

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	devices, etc. Based on observation and interview, the facility failed to maintain protection of corridor doors in 2 of 6 corridors in accordance of 19.3.6.3. This deficient practice could affect staff and at least 27 residents. Findings include: Based on observation with the Executive Director and the Maintenance Director on 02/01/18 between 11:39 a.m. and 12:07 p.m., the following was discovered: a) Salon corridor door was propped open with a plastic dust pan b) the 200 Hall shower room corridor door did not have positive latching hardware installed. The room was being used to store a lift, scale, four oxygen concentrators, trash can, and storage on shelves. c) Resident room 303 failed to latch when tested Based on interview at the time of each observation, the Executive Director and the Maintenance Director acknowledged the corridor doors were impeded and failed to latch. 3.1-19(b)	K 0363	**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 closure to the salon door was removed. The 200 shower corridor door had a latch installed. The stored items in the shower room were removed. Resident room 303 had the latch repaired **2) How the facility identified other residents:**	02/28/2018

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			Residents in the salon, room 303 and 200 hall shower room were affected **3) Measures put into place/ System changes:** Facility doors were tested and documented to be in working order. The maintenance department will audit Quarterly all doors. Staff will be in-service to write work orders for doors which do not properly latch. **4.) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required			

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	in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 9 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff and at least 66 residents. Findings include: Based on observations with the Executive Director and the Maintenance Director on 02/01/18 between 4:29 p.m. and 4:41 p.m., the following unsealed penetrations were discovered: a) a six inch by ten inch penetration in the smoke barrier attic near resident room 202 b) a four inch gap inside conduit in the attic smoke barrier near resident room 214 c) a two inch by two inch gap in the attic smoke barrier near resident room 401 Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged each aforementioned condition would not resist the passage of smoke and provided the measurements. 3.1-19(b)	K 0372	**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:** Penetrations in the attic near room 202,214 and 401 were sealed. Attic areas were inspected with no additional penetrations.	02/28/2018

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			2) How the facility identified other residents: Residents in rooms 202,214 and 401 could have been affected **3) Measures put into place/ System changes:** Maintenance will audit quarterly for penetrations in residents rooms thru the attic **4.) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have			

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	fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 2 of 2 100 Hall smoke barrier corridor doors would close to form a smoke resistant barrier. This deficient practice could affect staff and at least 28 residents. Findings include: Based on observation with the Executive Director and the Maintenance Director on 02/01/18 at 4:12 p.m., the two sets of corridor smoke doors in the 100 Hall hall swung in the same direction and left a quarter inch gap between the doors when fully closed. The door sets were not equipped with an astragal or coordinating device to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged the aforementioned condition and confirmed an astragal and coordinating device was not installed for the smoke barrier doors. 3.1-19(b)	K 0374	**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 100 hallway smoke door hardware has been replaced allowing appropriate closure. The quarter inch gap has been minimized with a filter.	02/28/2018

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			2) How the facility identified other residents: Residents in 100 hallway could have been affected **3) Measures put into place/ System changes:** Maintenance will audit door closures monthly for gaps. Staff will be in serviced to use work orders for doors which have gaps. **4.) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.			

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	18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical junction boxes observed was maintained in a safe operating condition in accordance with 19.5.1.1. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 2011 Edition, Article 314.28(C) requires all pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. This deficient practice could affect staff only. Findings include: Based on observation with the Executive Director and the Maintenance Director on 02/01/18 at 3:57 p.m., there was exposed wiring in an electrical box without a cover in the 100 Hall attic. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged the missing cover. 3.1-19(b)	K 0511	**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 100 attic electrical box has been covered. **2) How the facility identified other residents:** No resident was affected	02/28/2018

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			3) Measures put into place/ System changes: Maintenance will audit monthly all electrical boxes covers **4.) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on observation, record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans in accordance with 19.7.1.3 and 19.7.2.2. LSC 19.7.1.3 requires a copy of the plan shall be readily available at all times in the	K 0711	**The facility requests paper compliance for this citation.** This Plan of Correction is the	02/28/2018

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	telephone operator's location or at the security center. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on observation with the Executive Director and the Maintenance Director on 02/01/18 at 12:08 p.m., a set of 300 Hall cross corridor doors 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 the time of observation, a Registered Nurse was asked which fire doors she would move a residents across if she was evacuating the smoke compartment. She indicated the 300 Hall cross corridor doors that the Maintenance Director just indicated was not a complete smoke barrier. 3.1-19(b)		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:** Copies of the emergency and disaster preparedness manual are available at the front desk, executive director's office, maintenance, social services, activities, MDS and unit manager's offices **2) How the facility identified other residents:** No residents were affected **3) Measures put into place/**	

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			System changes: Manuals will be outdated as needed and reviewed quarterly during the table top exercise, Laporte Emergency Management meetings or CHUG **4.) How the corrective actions will be monitored:** The results of these table top exercises will be reviewed in Quality Assurance Meeting Quarterly for 6 months or until 100% compliance is achieved x3 consecutive months.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7			

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	Based on record review and interview, the facility failed to conduct quarterly fire drills for 3 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Fire Drill Evaluation Worksheet" form with the Executive Director and the Maintenance Director on 02/01/18 at 9:36 a.m., there was no documentation for a first shift fire drill in the third quarter of 2017. There was no documentation for a second shift fire drill in the first quarter of 2017. There was no documentation for a third shift fire drill in the second and third quarter of 2017 Based on interview at the time of record review, the Executive Director and the Maintenance Director were unable to provide further documentation. 3.1-19(b) 3.1-51(c)	K 0712	**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:** Fire drill sign in sheets could not be located **2) How the facility identified other residents:** No residents were affected	02/28/2018

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			3) Measures put into place/ System changes: Fire drills be performed monthly per regulations **4.) How the corrective actions will be monitored:** The results of the Fire drill will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 2 of 2 candles was maintained in	K 0753	**The facility requests paper compliance for this citation.**	02/28/2018

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	accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect staff and up to 34 residents. Findings include: Based on observation with the Executive Director and the Maintenance Director on 10/31/17 at 1:10 p.m. then again 1:57 p.m., the Planning office contained a candle with a wick. The Activities office contained a candle with a wick. Based on interview at the time of each observation, the Executive Director and the Maintenance Director confirmed a wick was in each candle. 3.1-19(b)		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:** Candle wicks were removed from 2 of the 2 candles **2) How the facility identified other residents:** No residents were affected **3) Measures put into place/ System changes:**	

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

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			Social Service director sent a letter informing residents and families regarding candles in the facility. A letter was also added to the admission packet for combustible decorations not allowed in the facility. Maintenance/designee will audit for these items monthly **4.) How the corrective actions will be monitored:** The results of the audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation, interview, and record review, the facility failed to enforce 1 of 1 policy for the use of portable space heaters in accordance with 19.7.8. This deficient practice could affect staff and up to 34 residents. Findings include:	K 0781	**The facility requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation	02/28/2018

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	Based on observation with the Executive Director and the Maintenance Director on 02/01/18 at 11:54 a.m., a space heater was discovered in resident room 226. Based on interview and record review at the time of observation, the Executive Director and the Maintenance Director acknowledged the space heater and confirmed that the facility's space heater policy does not allow space heaters in the facility. 3.1-19(b)		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:** Spacer Heater was removed from Room 226. All other rooms were found to be in compliance **2) How the facility identified other residents:** Resident in room 226 could have been affected **3) Measures put into place/ System changes:** Social service Director sent a letter informing residents and	

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			families regarding space heaters in the facility. The maintenance department/designee will audit weekly all rooms for space heaters. **4.) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed			

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	wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 9 of 9 flexible cords were not used as a substitute for fixed wiring according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 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 up to 39 residents. Findings include: Based on observation with the Executive Director and the Maintenance Director on 02/01/18 between 11:23 a.m. and 1:57 p.m., the following was discovered: a) a surge protector was powering a coffee pot and a microwave in the Admissions office b) a surge protector was powering a refrigerator in resident room 303 c) a surge protector was powering another surge protector powering computer components in the Temporary Nursing office d) a surge protector was powering a microwave in the Mechanical room e) a surge protector was powering another surge protector powering communications equipment in the Tel-com room f) a surge protector was powering another surge protector powering computer components in the Activities room Based on interview at the time of each	K 0920	**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:** Flexible electrical cords were removed from the facility. A ground fault Circuit interrupter was placed in the 300 Hall utility closet.	02/28/2018

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	observation, the Executive Director and the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b) 2. Based on observation, record review, and interview, the facility failed to install 1 of 1 power strip according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 110.3(B) Installation and Use, states listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. This deficient practice affects staff and up to 34 residents. Findings include: Based on observation with the Executive Director and the Maintenance Director on 02/01/18 at 11:42 a.m., a power strip was powering an oxygen concentrator in resident room 204. Based on interview at the time of observation, the Executive Director and the Maintenance Director was unable to provide UL 60601-1 documentation for the permanently installed power strip in a patient care area. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 300 Hall Utility Closet was provided with a ground fault circuit interrupter (GFCI) protection against electric shock. LSC sections 9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8 Ground-Fault Circuit-Interrupter Protection for		**2) How the facility identified other residents:** No residents were affected **3) Measures put into place/ System changes:** Managers were inserviced on the use of flexible cords. Maintenance/designee will do weekly audits looking for flexible electrical cords. **4.) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	

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	Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff only. Findings include: Based on observation with the Executive Director and the Maintenance Director on 02/01/18 at 12:02 p.m., the 300 Hall Utility Closet room had one GFCI receptacle within three feet of a sink. When the GFCI tester button was pressed, power was not interrupted on the GFCI receptacle. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged the aforementioned condition and confirmed the receptacle failed to trip when tested. 3.1-19(b)			
K 0923 SS=D Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated			

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	from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 200 Hall oxygen transfill room was protected in accordance with 11.2.3.2. 2012 NFPA 99 11.3.2.3 requires oxidizing gases such as oxygen shall be separated 5 feet from combustibles or materials. This deficient practice could affect staff only. Findings include: Based on observation with the Executive Director and the Maintenance Director on 03/02/17 at 10:27	K 0923	**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	02/28/2018

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	a.m., the 200 Hall oxygen transfill room contained liquid oxygen stored within 5 feet of a trash can and a wooden table on wheels. Based on interview at the time of observation, the Executive Director and the Maintenance Director confirmed the combustible storage was within five feet of liquid oxygen containers. 3.1-19(b)		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 trash can and wooden table were removed from the oxygen transfill room **2) How the facility identified other residents:** No resident was affected **3) Measures put into place/ System changes:** Unit managers were inserviced on having combustible storage within 5 feet of liquid oxygen. Maintenance/designee will audit weekly for combustible material near liquid oxygen.	

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			4.) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 400 Hall transfill room used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire-resistive construction. This deficient practice could affect staff and at least 32 residents. Findings include: Based on an observation with the Executive Director and the Maintenance Director on	K 0927	**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	02/28/2018

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	02/01/18 at 12:16 p.m., the 400 Hall transfill room corridor door failed to latch into the frame when tested. Based on interview at the time of observation, the Executive Director and the Maintenance Director confirmed the corridor door failed to latch when tested. 3.1-19(b)		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 400 hall transfill room corridor door latch was repaired **2) How the facility identified other residents:** No residents were affected **3) Measures put into place/ System changes:** Maintenance/designee will audit for door closure monthly. Staff was in serviced on writing working orders when latched are found not to be in working order. **4.) How the corrective actions will be monitored:**	

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	