DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155344	A. BUILDING -- B. WING	06/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF MICHIGAN CITY	802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/21/22 Facility Number: 000236 Provider Number: 155344 AIM Number: 100287700 At this Emergency Preparedness survey, Life Care Center of Michigan City was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 120 certified beds. At the time of the survey, the census was 72. Quality Review completed on 06/23/22	E 0000	Please reference the enclosed 2567 as Plan of Correction for the June/ 21/22 life safety survey. I am respectfully requesting paper compliance for this survey. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth facts alleged or agreement by the provider of the truth facts alleged or conclusions set forth in the statement of deficiencies. The POC is executed solely because it is required by provisions of the Federal and State Law. The facility appreciates the time and dedication of the survey team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the people in our community. 7/7/2022- additional documentation uploaded and changes made to plan. We would like to continue to request paper compliance	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR	K 0000	Please reference the enclosed 2567 as Plan of Correction for the June/ 21/22 life safety survey.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	483.90(a). Survey Date: 06/21/22 Facility Number: 000236 Provider Number: 155344 AIM Number: 100287700 At this Life Safety Code survey, Life Care Center of 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 in the 300, 400 and 500 wings and Type IV (2HH) construction in the 100 and 200 wings and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in the resident rooms. The building is partially protected by a 200 kW diesel powered generator. The facility has a capacity of 120 beds dually certified for Medicare and Medicaid and had a census of 72 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility had one detached garage and two sheds used for facility storage which were not sprinklered. Quality Review completed on 06/23/22		I am respectfully requesting paper compliance for this survey. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth facts alleged or agreement by the provider of the truth facts alleged or conclusions set forth in the statement of deficiencies. The POC is executed solely because it is required by provisions of the Federal and State Law. The facility appreciates the time and dedication of the survey team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the people in our community. 7/7/2022- additional documentation uploaded and changes made to plan. We would like to continue to request paper compliance	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits			

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	Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview the facility failed to provide an exit discharge from their property to the public way in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.2, 19.2.1, 19.2.7, 7.1, 3.3.83, 3.3.218, 7.7, 7.7.1 and 7.7.4. This deficient practice could affect approximately 10 residents and staff. Findings include: Based on observation on 06/21/2022 during a tour of the facility with the Senior Maintenance Director from 12:34 p.m. to 1:44 p.m., the exterior exit door by rooms 409 and 410 discharged to a sidewalk and bridge that led to the parking lot on the neighboring property. The exit discharge did not lead to the public way. Based on interview at the time of observation, the Senior Maintenance Director stated that the facility did not own the property that the exit discharged onto and agreed it did not lead to the public way. This finding was reviewed with the Executive Director and Senior Maintenance Director at the exit conference. 3.1-19(b)	K 0271	K271 On 6//21/22 The senior maintenance director did an audit on all exit discharge doors to verify no additional doors failed to provide an exit discharge on to Life Care property. No additional concerns were identified. Zero residents were harmed from the alleged deficient practice. On 6/22/22 the ED inserviced the maintenance director on the need for exit doors to discharge on to our property. The Maintenance Director obtained a bid on 7/6/22 to level the ground and install a sidewalk that will allow discharge exit on to facility property. The ED submitted necessary paperwork to authorize project on 7/7/22 .Upon approval, the Maintenance director will schedule the project and it will be completed by 9/21/22 To insure future compliance, the maintenance director will audit all exit doors to verify exits meet codes including free from obstructions, hard packed all weather surface, and discharge on to facility property 2x monthly for	09/21/2022

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			two months, monthly for four months. Audits will be reviewed at monthly QUAPI meeting to identify trends and review for any concerns.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, and a spare sprinkler cabinet large enough to fit all spare sprinkler heads. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings	K 0353	On 6//21/22 The senior maintenance director did an audit on sprinkler cabinets and sprinkler heads to verify proper storage and enough spares. No additional concerns were identified. Zero residents were harmed from the alleged deficient practice On 6/22/22 the ED inserviced the maintenance director on the need for appropriate storage cabinets and spare sprinkler heads and appropriate types. On 6/28/22 the	07/08/2022

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	of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observation with the Senior Maintenance Director on 06/21/22 during a tour of the facility from 12:34 p.m. to 1:44 p.m., there were two spare sprinkler cabinets by the wet riser and were not large enough to contain all sprinkler heads and prevent damage to the sprinkler heads. When the cabinets in riser room were opened, the cabinets contained twelve more sprinkler heads than spots available. Additionally, there were not high temperature spare sprinklers to replace those in the boiler room. Based on interview at the time of the observations, the Senior Maintenance Director agreed the two cabinets were not large enough to contain all spare sprinkler heads and the appropriate types were not present on the premises. These findings were reviewed with the Executive Directed and Senior Maintenance Director at the exit conference. 2. Based on observation and interview, the facility failed to maintain the ceiling construction throughout the facility. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified		maintenance director ordered a new cabinet. On 6/28/22the maintenance director ordered additional and appropriate sprinkler heads. On 6/21/22 the maintenance director repaired the hole around the sprinkler escutcheon with fire caulk, and there is no longer a penetration. On 6/21/22 the maintenance director did a full house audit to verify that there were no additional penetrations of the ceiling that could delay the activation of the sprinkler system. No additional concerns were found. Zero residents were harmed from the alleged deficient practice. On 6/21/22 the ED inserviced the director of maintenance on maintaining the ceiling system to include free from penetration. To insure future compliance, the maintenance director will audit all sprinkler heads and cabinets to verify that cabinets have sufficient storage space and appropriate, additional sprinkler heads are available. The maintenance director will audit the ceiling for penetrations and fix any identified areas of concern 2x monthly for two months, monthly for four months Audits will be reviewed at monthly QUAPI meeting to identify trends and review for any concerns.	

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	temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect at least 4 residents and staff near west soiled utility. Findings include: Based on observation with the Senior Maintenance Director during a tour of the facility from 12:34 p.m. to 1:44 p.m. on 06/21/22, a hole of an approximate 1/4" was discovered around the sprinkler escutcheon in west soiled utility. This hole penetrated through the ceiling exposing the space above and could delay the activation of the sprinklers installed in the room. Based on interview at the time of observation, the Senior Maintenance Director confirmed the penetration in soiled utility and would make a repair. This finding was reviewed with the Executive Director and Senior Maintenance Director at the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors 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			

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	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 devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 59 resident room doors to the corridor would completely resist the passage of smoke. This deficient practice could affect at least 7 residents and staff in the vicinity of room 301. Findings include: Based on observation on 06/21/2022 at 12:59 p.m. during a tour of the facility with the Senior	K 0363	On 6/21/22 the senior maintenance director repaired the crescent moon shaped opening on door to room 301. On 6/22/22 The ED inserviced the director of maintenance on doors that need to be smoke resistant. On 6/22 the senior maintenance director did a full house audit to verify that all doors that are required to be	07/08/2022

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	Maintenance Director, the corridor door to unoccupied resident room 301 next to the shower room had a one-quarter inch crescent moon shaped opening above the handle to the door that was open to the corridor. A flashlight was used on the corridor side of the hole, which illuminated through the door; making the door not smoke tight. Based on interview at the time of observation, the Senior Maintenance Director agreed there was an opening above the handle of resident room 301 and would have the door handle adjusted to make the door smoke tight. This finding was reviewed with the Executive Director and Senior Maintenance Director at the exit conference. 3.1-19(b)		smoke resistant were free of any holes or other spots that interferes with the smoke resistance of the door. No additional concerns were found. Zero residents were harmed from the alleged deficient practice. To insure future compliance, the maintenance director will audit 100% of doors for smoke resistance 2x monthly for two months, monthly for four months Audits will be reviewed at monthly QUAPI meeting to identify trends and review for any concerns.	
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2			
	Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause	K 0522	On 6/21/22 the senior maintenance director cleaned the intake, removing the lint. On 6/21/22, the senior maintenance director inspected the additional dryer vent and found no concerns.	07/08/2022

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	physical problems for all staff in the laundry room. Findings include: Based on observations during a tour of the facility with the Senior Maintenance Director on 06/21/22 at 1:40 p.m., the laundry room had fuel-fired dryers with a fresh air intake that was almost completely covered with lint and dirt. This condition does not allow for fresh air to completely enter the room. Based on an interview at the time of observation, the Senior Maintenance Director agreed the intake was covered with lint and would have it cleaned. This finding was reviewed with the Executive Director and Senior Maintenance Director during the exit conference. 3.1-19(b)		On 6/22/22 The ED inserviced the director of maintenance on the care of heating devices including the removal of lint. To insure future compliance, the maintenance director will audit 100% of dryer vents to verify they are free from lint weekly for 2 months, 2X monthly for 4 months. Audits will be reviewed at monthly QUAPI meeting to identify trends and review for any concerns.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and			

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	automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on observation and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 or 2 generators for 12 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Furthermore, 2012 NFPA 101 Section 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect all occupants.	K 0918	On 6/21/22 the senior maintenance director verified that the records for the other generator for maintenance and testing were complete and accurate. No other issues were found. Zero residents were harmed from the alleged deficient practice On 6/22/22 The ED inserviced the director of maintenance on essential electric systems maintenance and testing. The facility intends on disposal of the 30W generator. Maintenance Director will schedule bids to empty the fuel by 7/20/22. The maintenace director secured a bid for a crane to remove the generator on 6/30/22. The ED submitted paperwork for project approval on 7/7/2022. Upon approval the maintenace director will schedule removal of	09/21/2022

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	Findings include: Based on observation during a tour of the facility with the Senior Maintenance Director on 06/21/22 from 12:34 p.m. to 1:44 p.m., there were two emergency generator annunciator panels at the west nurse station. One of the annunciator panels, for the 30kW generator, had the 'Not in Auto" light (red), "Common Fault" light (red), "Alarm silenced light (red) illuminated. Based on interview at the time of observation, the Senior Maintenance Director stated the generator was not in auto mode and that is why the red lights are illuminated and that no systems of the facility are connected to the 30kW generator. The Senior Maintenance Director stated that he does not do a monthly load test or weekly visual inspection since there is nothing connected to it. He further stated that the 30kW generator was installed as a temporary measure in 2008 while the 200kW generator was being installed. The facility systems are connected to the 200 kW generator, whose annunciator panel was next to the 30kW annunciator panel. Based on interview at the time of observation, the Senior Maintenance Director agreed the 30kW generator annunicator panel was obvious to the public at the west nurse's station and the generator was not being maintained. This finding was reviewed the Executive Director and the Senior Maintenance Director during the exit conference. 3.1-19(b)		the generator with completion no later than 9/21/22. To insure future compliance, the maintenance director will audit 100% of generator records to verify maintenance and testing records are complete 2x monthly for 2 months monthly for 4 months. . Audits will be reviewed at monthly QUAPI meeting to identify trends and review for any concerns.	