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	12/13/2018

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. --		E 0000		
	A Emergency Preparedness Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/13/2018 Facility Number: 000076 Provider Number: 155156 AIM Number: 100271060 At this Emergency Preparedness survey, Aperion Care Arbors Michigan City was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR Subpart 483.73. The facility is certified for 180 beds, however is set up for 164. The facility maintains 147 dual Medicare and Medicaid beds and 33 Medicare only beds. At the time of the survey, the census was 134. Quality Review completed on 12/17/18 - DA			
K 0000 Bldg. 01		K 0000		
	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: 12/13/18			

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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	Facility Number: 000076 Provider Number: 155156 AIM Number: 100271060 At this Life Safety Code survey, Aperion Care Arbors 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 is certified for 180 beds, however is set up for 164. The facility maintains 147 dual Medicare and Medicaid beds and 33 Medicare only beds. At the time of the survey, the census was 134. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 12/17/18 - DA			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits 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			

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	travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to maintain 2 of 16 exits in accordance with LSC 7.1.10.1 as required by Section 19.2.1. Section 7.1.10.1 states that aisles, passageways, corridors, exit discharges, exit locations, and accesses are continuously maintained free of all obstructison to full use in case of emergency. This deficient practice affects staff and at least 11 residents in the 200 Hall and 8 residents in the Memory Care East Hall. Findings include: During a tour of the facility with the Maintenance Director on 12/13/18 at 12:18 p.m. the 200 Hall West exit discharge was covered with several inches of leaves and sticks. Again, at 1:30 p.m. the Memory Care East Hall exit discharge was covered with leaves. Based on interview are the time of both observations, the Maintenance Director agreed that the leaves in the exit discharge could impede persons exiting from the building in an emergency. 3.1-1.9(b)	K 0271	**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 two exits cited were cleared of leaves prior to the completion of the surveyor **2) How the facility identified other residents:** No residents were affected, emergency exits were not utilized during the time period. **3) Measures put into place/ System changes:** Maintenance personnel will check door clearance 5 times weekly and add this process to the daily maintenance logs.	12/27/2018

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			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:	
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 2 of over 100 rooms in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff	K 0351	**K351** **The facility requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation of compliance.	12/27/2018

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	only in the 200 Hall. Findings include: During a tour of the facility with the Maintenance Director on 12/13/18 at 1:02 p.m., it was found that 1 of 2 sprinklers was missing an escutcheon in the 200 Hall Pantry, and 1 of 1 escutcheon was missing from the sprinkler in the 200 Hall Soiled Utility Room. Based on interview at the time of observations, the Maintenance Director agreed that sprinklers needed escutcheons. 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:** Escutcheons were placed on the two sprinkler heads cited **2) How the facility identified other residents:** No residents were affected, no fire emergencies occurred during this time frame no any other incident related to this citation. **3) Measures put into place/ System changes:** Maintenance personnel will add escutcheon checks in addition to the weekly sprinkler head monitoring and add it to the weekly 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 0712 SS=C 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 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Evaluation Worksheet" documentation with the Maintenance Director during record review from 9:30 a.m. to 10:00 a.m. on 12/13/18, second shift (2:00 p.m. to 10:00 p.m.) fire drills conducted on 02/27/18, 04/30/18, 07/31/18, and 10/29/18 were conducted at, respectively, 2:30 p.m., 3:00 p.m., 2:29 p.m., and 2:22 p.m. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned second shift fire drills were not conducted at unexpected times under varying conditions.	K 0712	**K 712 Fire Drills** **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 drills are now scheduled at	12/27/2018

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	3.1-19(b)		unexpected times in varying conditions for each shift over each quarter **2) How the facility identified other residents:** No residents were affected as no fires or others adverse incidences occurred during this time frame. **3) Measures put into place/ System changes:** Fire drills be performed monthly per regulations, dated, timed with sign in logs and the records maintained in the maintenance log book. **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.	