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	06/11/2019

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. --	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: 06/11/19 Facility Number: 000076 Provider Number: 155156 AIM Number: 100271060 At this Emergency Preparedness survey, Aperion Care Arbors at Michigan City was found in substantial 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. The facility maintains 147 dual Medicare and Medicaid beds and 33 Medicare only beds. At the time of the survey, the census was 141. Quality Review on 06/12/19	E 0000	The facility requests paper compliance for this Plan of Correction. 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.	
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	E 0039	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	06/28/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	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). This deficient practice could affect all occupants. Findings include: During record review with Administrator and Maintenance Director on 06/11/19 at 10:57 a.m. the facility provided documentation for participation in exercises to test the emergency plan, however it was incomplete. The facility failed to provide documentation for: a) A second full-scale exercise that is community-based or individual, facility-based. or b) A tabletop exercise that included 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 the emergency plan. or c) A qualifying actual natural or man-made		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 facility activated the emergency plan on 2/2/2019. The plan was activated in response to a burst fire sprinkler. 2) How the facility identified other residents: All residents would have been affected by this incident. 3) Measures put into place/ System changes: An analysis of the facility emergency plan was analyzed and documented on 6/26/19. 4) How the corrective actions will be monitored: The results of any exercises will be reviewed in Emergency Preparedness meetings monthly for 3 months to ensure all details were documented. 5) Date of compliance: 6/28/19	

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	emergency that requires activation of the emergency plan. Based on interview at the time of record review, the Administrator and Maintenance Director stated that the facility activated the emergency plan in early 2019 in response to a burst fire sprinkler pipe and result flood. However, they were unable to provide documentation and analysis of the event at the time of request.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/11/19 Facility Number: 000076 Provider Number: 155156 AIM Number: 100271060 At this Life Safety Code survey, Aperion Care 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 in all resident sleeping rooms. The majority of the building is partially protected by a 45 kW natural gas powered	K 0000	The facility requests paper compliance for this Plan of Correction. 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.	

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	emergency generator. Resident rooms 301-312, which contain a ventilator unit, are fully protected by a 40 kW natural gas powered generator. The facility is certified for 180 beds. The facility maintains 147 dual Medicare and Medicaid beds and 33 Medicare only beds. At the time of the survey, the census was 141. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review on 06/12/19			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 12 smoke barrier doors per 4.6.12.3. LSC 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 staff and at least 19 residents who reside in the adjacent smoke compartments. Findings include: During a facility tour with the Maintenance Director on 06/11/19 at 11:34 a.m., the set of smoke barrier doors by resident room 401 was provided with latching hardware but failed to latch when tested. Based on interview at the time of	K 0100	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	06/28/2019

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	observation, the Maintenance Director acknowledged the aforementioned condition, and agreed that doors with latching hardware should latch when closed. 3.1-19(b)		required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: The smoke barrier doors hardware by room 401 has been adjusted allowing appropriate closure. 2) How the facility identified other residents: Residents in the 400 hallways could have been affected 3) Measures put into place/ System changes: Maintenance will test door closures monthly for proper latching in monthly Preventative Maintenance program 4.) How the corrective actions will be monitored: The results of these tests will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. 5) Date of compliance: 6/28/19	
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,			

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	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 Based on record review and interview, the facility failed to ensure 1 of 1 private fire hydrant was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2011 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Table 7.1.1.2 requires wet and dry barrel hydrants to be inspected annually and after each operation. This deficient practice affects all residents in the facility. Findings include: During record review with the Administrator and Maintenance Director on 06/11/19 at 9:38 a.m., the facility failed to provide documentation for the testing and inspection of one private wall fire hydrant located in the rear of the building. Based on an interview at the time of record review, the Maintenance Director agreed that the hydrant had not been tested in the previous twelve month period. 3.1-19(b)	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 private fire hydrant was inspected on 6/28/19 2) How the facility identified other residents: All residents could have been affected by this practice	06/28/2019

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			3) Measures put into place/ System changes: Maintenance will put this inspection in the Preventative Maintenance Program to ensure the hydrant is inspected annually and after each operation. 4.) How the corrective actions will be monitored: The Maintenance Director will bring his inspection binder to the QA monthly x 6 months to ensure inspections are completed and are timely. 5) Date of compliance: 6/28/19	
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 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 1 of 12 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke	K 0374	The facility requests paper compliance for this citation. This Plan of Correction is the	06/28/2019

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	barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect staff and up to 28 residents residing in the adjacent smoke compartments to the Memory Care East Hall barrier doors. Findings include: During a tour of the facility with the Maintenance Director on 06/11/19 at 12:31 p.m., the barrier doors located in the Memory Care East Hall were obstructed from closing by two chairs. This was acknowledged by the Maintenance Director, who immediately relocated the chairs to an off corridor area, which allowed the doors to close freely when released. It was noted that this was corrected prior to the facility exit. 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: The chairs were immediately removed from obstructing the barrier doors. 2) How the facility identified other residents: All residents in the Memory Care East hallway could have been affected 3) Measures put into place/ System changes: Activity Director/designee will ensure chairs are not placed in front of fire barrier doors during activities, when conducting activities in the main sitting areas of the memory care unit by audit x5 days a week for 3 months and periodically thereafter and in-serviced activity staff about not placing chairs in front of doors during activities.	

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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. 5) Date of compliance: 6/28/19	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure 1 of 1 trash carts near the salon was stored in accordance with with 19.7.5.7. This deficient practice could affect staff and up to 15 residents in the smoke compartment. Findings include:	K 0754	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	06/28/2019

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	During a tour of the facility with the Maintenance Director on 06/11/19 at 12:20 p.m., a 1/2 Cubic Yard (100 gallon) mobile trash cart was located unattended in the corridor near the salon. When interviewed, the Maintenance Director agreed the cart was unattended and exceeded the maximum allowed unattended. The housekeeping employee was located in a different area of the building. 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 container was removed immediately from the hallway. 2) How the facility identified other residents: All residents and staff could have been affected by this incident. 3) Measures put into place/ System changes: Housekeeping & Maintenance staff were in-serviced on leaving the trash container unattended in the hallways. Maintenance will monitor during PM rounds x5 a week for 3 months to ensure no trash containers are left unattended in any halls. 4) How the corrective actions will be monitored: The results of the monitoring rounds will be reviewed in Quality Assurance Meeting monthly for 3 months	

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			5) Date of compliance: 6/28/19	
K 0918 SS=C 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 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,			

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	NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to maintain 2 of 2 Essential Electrical Systems in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems, Chapter 5, Emergency Power Supply (EPS), 5.1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): (1) Liquid Petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas NFPA 110, Chapter 2, states that NFPA 70, National Electrical Code, shall be met has a requirement of NFPA 110. NFPA 70, Section 700.12(B)(3) states: Prime movers shall not be solely dependent on a public utility gas system for their fuel supply - except: Where acceptable to the authority having jurisdiction, the use of other than on-site fuels shall be permitted where there is a low probability of a simultaneous failure of both the off-site fuel delivery system and power from the outside electrical utility company. The CMS 2009 Natural Gas Generator Backup Fuel Source Letter Requirements states: The letter of reliability from the vendor regarding the fuel supply must contain all of the following: 1. A statement of reasonable reliability of the natural gas delivery 2. A brief description that supports the statement regarding the reliability 3. A statement that there is a low probability of interruption of the natural gas 4. A brief description that supports the statement regarding the low probability of interruption 5. The signature of technical personnel from the	K 0918	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: A Letter of Reliability has been obtained from the facility's natural gas provider. 2) How the facility identified other residents: All residents and staff could have been affected by this incident. 3) Measures put into place/ System changes: The letter of reliability will be reviewed annually and update as needed with the provider. 4) How the corrective actions will be monitored:	06/28/2019

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	natural gas vendor. This deficient practice could affect all building occupants. Findings include: During record review with the Administrator and Maintenance Director on 06/11/19 at 10:12 a.m. vendor inspection documentation indicated that the facility had two natural gas powered generators, a 45 kW Type II generator which provided emergency power to the majority of the building, and a 40 kW Type I generator, which provided full back-up power for the ventilator unit. When requested, the facility was unable to provide a Letter of Reliability from the natural gas provider. Based on interview at the time of record review, the Administrator and the Maintenance Director confirmed that they were unable to locate a Letter of Reliability at the time of request. 3.1-19(b)		The letter will be reviewed twice a year in Emergency Preparedness meetings to ensure ongoing compliance. 5) Date of compliance: 6/28/19	