STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 01 B. WING	12/13/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 12/13/16 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 483.70(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 113 at the time of this survey.	K 0000		

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

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	All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 12/19/16-DA			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation, the facility failed to ensure 1 of 12 exit discharges were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency per LSC 7.1.10.1. This deficient practice could affect staff and at least 7 residents. Findings include: Based on observation with the Administrator on 12/13/16 at 11:30 a.m., the 100 Hall Courtyard exit discharge had about two inches of snow throughout the discharge path. Based on interview at the	K 0211	**K211** **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*	01/12/2017

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	time of observation, the Administrator confirmed this exit path was not shoveled like the other exit discharges and provided the measurement. 3.1-19(b)		*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:** Snow was removed from the 100 Unit Courtyard Exit discharge. **2) How the facility identified other residents:** All other exits were checked, and no other exits had snow or other obstruction on the exit discharge. **3) Measures put into place/ System changes:** In-serviced maintenance staff on the requirements regarding exit discharge. Audit tool was created to monitor	

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			the exit discharges to ensure that they are free of obstruction. **4) How the corrective actions will be monitored:** Audits will be completed 3 times per week under the supervision of the Maintenance Director or designee on at least 3 exits to ensure that the exit discharge is free from obstructions. 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:** **01/12/17**	
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation and interview, the	K 0226	**K226**	01/12/2017

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	facility failed to ensure 2 of 4 fire door sets were arranged to automatically close and latch. LSC 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80 6.1.4.3.1 states the fire door shall latch upon closing. This deficient could affect 71 residents in 3 smoke compartments when occupied. Findings include: Based on observation with the Maintenance Director and the Administrator on 12/13/16 at 9:15 a.m. then again at 9:39 a.m., the South 200 Hall fire doors failed to latch. Then again, the North 400 Hall fire doors failed to latch. Based on interview at the time of each observation, Maintenance Director and the Administrator confirmed the cross corridor doors were fire barrier doors and had 90 minute fire resistive labels. 3.1-19(b)		**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 South 200 Hall fire doors and the North 400 Hall fire doors were repaired. **2) How the facility identified other residents:**	

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			All other fire doors were checked and no other doors were identified. **3) Measures put into place/ System changes:** Re-educated maintenance staff on the requirements regarding fire doors. An audit tool was created to monitor the closure and latching of the fire doors. **4) How the corrective actions will be monitored:** Three sets of fire doors will be monitored three times weekly under the supervision of the Maintenance Director or designee to ensure they close and latch when released. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or	

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			until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** **01/12/17**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING 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. 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 Area Automatic Sprinkler Seperation 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)			

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	f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220)			
	Based on observation and interview, the facility failed to ensure 1 of 1 Housekeeping storage office greater than fifty square feet was protected in accordance with 19.3.2.1.5. LSC 19.2.1.3 requires doors to hazardous areas shall be self-closing or automatic-closing. This deficient practice could affect staff and 22 residents in the smoke compartment. Findings include: Based on observation with the Maintenance Director and the Administrator on 12/13/16 at 9:23 a.m., the room contained thirty six cardboard boxes filled with housekeeping supplies. Additionally, the room had metal shelving holding at least 100 hundred pieces of linen. The corridor door did not have a self-closing device installed. Based on interview at the time of observation, the Maintenance Director and the Administrator acknowledged the aforementioned condition and confirmed the room was greater than 50 square feet. 3.1-19(b)	K 0321	**K321** **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:** Self-closure installed on the housekeeping office.	01/12/2017

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			2) How the facility identified other residents: No other storage areas >fifty square feet were identified as not having self-closures. **3) Measures put into place/ System changes:** Maintenance educated on the requirement for self-closing doors in storage spaces. An audit tool was designed to check for the presence and function of self-closing apparatus on all applicable storage areas. **4) How the corrective actions will be monitored:** An audit will be completed three times weekly under the supervision of the Maintenance Director or designee on three storage doors to check for the presence and function of	

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			self-closing apparatus. 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:** **01/12/17**	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			

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	Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchens. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff only. Findings include: Based on observation with the Environmental Services Director and the Maintenance Technician #1 on 11/09/16 at 1:06 p.m., the Kitchen contained a UL 300 hood system. Based on interview, the Food Service Director was asked what she would do if there was a fire underneath the hood. She replied she would leave the room to find the gas shut off valve, then go to the electrical panel to shut off the hood, then get the extinguisher. She failed to indicate pulling the hood pull station. Based on interview, the Maintenance Technician #1 acknowledged the aforementioned condition. 3.1-19(b)	K 0324	**K324** **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:** Dietary Director in-serviced on the proper activation of the UL300 hood system. This practice could affect staff only.	01/12/2017

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			2) How the facility identified other residents: All other dietary personnel were in-serviced on the proper activation of the UL300 hood system. This practice could affect staff only. **3) Measures put into place/ System changes:** All dietary personnel were in-serviced on the proper activation of the UL300 hood system. An audit was devised to test the knowledge of the dietary personnel. **4) How the corrective actions will be monitored:** An audit will be completed by the administrator or designee to test the knowledge of three members of the dietary personnel weekly regarding the activation of the UL300 hood system.	

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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. **5) Date of compliance:** **01/12/17**	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National	K 0345	**K345** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	01/12/2017

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	Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NPFA 72, 14.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 12/13/16 between 7:50 a.m. and 8:41 a.m., no documentation for a fire alarm sensitivity test was available for review. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition and confirmed no other documentation was available for review. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 1 of 1 Front Annunciator panel would connect to the main fire alarm panel per 4.6.1.2. LSC 4.6.1.2 states any requirements that are essential for the safety of building occupants and that are not specifically		*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:** Sensitivity testing with readings will be completed. Front Annunciator panel was connected to the main fire alarm panel. **2) How the facility identified other residents:** Any resident could be affected by inaccurate sensitivity testing. No other annunciator panels were not connected to the main fire alarm panel. **3) Measures put into place/ System changes:** Maintenance staff in-serviced on the need to have readings on the sensitivity testing. Additional in-service was completed on the need for the annunciator panels to remain connected to the main fire alarm panel. An audit tool was devised to ensure that documentation was present for the sensitivity testing.	

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	provided by this *Code* shall be determined by the authority having jurisdiction. This deficient practice could affect staff and at least 32 residents open to the dining room. Findings include: Based on record review with the Maintenance Director on 12/13/16 between 7:50 a.m. and 8:41 a.m., the quarterly testing documentation from Ryan Fire Protection Inc on 10/18/16 indicated "the annunciator located By Main Entrance is temporarily disconnected due to the annunciator causing issues with the fire alarm panel. This issue is being handled by another company." Based on interview at the time of record review, the Maintenance Director confirmed no other work has been done. 3.1-19(b)		An audit tool was devised to check annunciator panels for connection to the main fire alarm panel. **4) How the corrective actions will be monitored:** An audit tool will be completed weekly by the maintenance director or designee to ensure that the documentation for the sensitivity testing is present and contains reading results. An audit tool will be completed weekly by the maintenance director or designee on two annunciator panels to ensure that they are connected to the main fire panel. 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:** **01/12/17**	
K 0351 SS=E 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			

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	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 provide sprinkler coverage for 1 of 1 roof extending over four feet. NFPA 13, 2010 Edition, Section 8-15.7.2 states sprinklers shall be permitted to be omitted where the exterior roofs, canopies, balconies, decks or similar projections exceeding 4 feet in width are noncombustible, limited combustible or fire retardant-treated wood as defined in NFPA 703, Standard for Fire Retardant-Treated Wood and Fire-Retardant Coatings for Building Materials. This deficient practice could affect staff and up to 32 residents in the Dining Room smoke compartment. Findings include:	K 0351	**K351** **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*	01/12/2017

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	155156	A. BUILDING 01 B. WING	12/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Based on observation with the Administrator on 12/13/16 at 11:36 a.m., the roof extended 8 feet from the exit by the Business office. The eight feet of area did not contain sprinkler protection. Based on interview at the time of observation, the Administrator acknowledged the aforementioned condition. 3.1-19(b)		*is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Sprinkler will be installed outside the exit by the business office. **2) How the facility identified other residents:** All other exits were checked and no other exits with a roof extending over four feet was without a sprinkler. **3) Measures put into place/ System changes:** Maintenance staff educated on the requirements for sprinkler coverage outside of exits. An audit was devised to monitor the sprinkler coverage. **4) How the corrective actions will be monitored:** Audit will be completed once weekly under the direction of the	

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			maintenance director or designee on two exits to determine if sprinkler is required and remains present. 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:** **01/12/17**	
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 Based on record review and interview,	K 0353	**K353**	01/12/2017

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	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: Based on record review with the Maintenance Director and the Administrator on 12/13/16 between 7:50 a.m. and 8:41 a.m., the sprinkler system was inspected quarterly, except no documentation was available for the fourth quarter of 2015. No documentation was available for the monthly gauges or control valves inspection. Based on interview at the time of observation, the Maintenance Director and the Administrator acknowledged the aforementioned condition. 3.1-19(b)		**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 new quarterly sprinkler inspection will be completed. Monthly gage and control valve inspections initiated. **2) How the facility identified other residents:**	

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			Less frequent sprinkler inspections, gage inspections, or control valve inspections could potentially affect all residents. **3) Measures put into place/ System changes:** Maintenance personnel in-serviced on the need for quarterly sprinkler inspections, and monthly gage and control valve inspections. Audit created to monitor for the completion of required sprinkler, gage, and control valve inspections. **4) How the corrective actions will be monitored:** Audit will be completed weekly by maintenance director or designee to check for completion of sprinkler inspection, monthly gage inspection and monthly control valve inspection and ensure paperwork is present. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is	

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			achieved x3 consecutive months. **5) Date of compliance:** **01/12/17**	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 400 Hall Dining room portable fire extinguishers was installed correctly in accordance with 19.3.5.12. NFPA 10, the Standard for Portable Fire Extinguishers, 6.1.3.8.3 in no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. This deficient practice could affect staff and up to 21 residents. Findings include: Based on observation with the Maintenance Director and the Administrator on 12/13/16 at 9:37 a.m., the 400 Hall Dining room fire extinguisher was sitting on the floor unprotected. Based on interview at the	K 0355	**K355** **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*	01/12/2017

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	time of observation, the Maintenance Director and the Administrator acknowledged the aforementioned condition.		*is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The fire extinguisher in the 400 dining room was properly installed. **2) How the facility identified other residents:** All other fire extinguishers were checked and there were no other extinguishers within 4 inches of the floor. **3) Measures put into place/ System changes:** Maintenance staff educated on the need to have fire extinguishers installed greater than 4 inches from the floor. An audit was created to check extinguishers for proper installation and placement.	

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			4) How the corrective actions will be monitored: An audit will be completed by maintenance director or designee on five extinguishers weekly to determine if they are properly installed. 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:** **01/12/17**	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 2 100 Hall corridors was separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met	K 0361	**K361** **The facility requests paper compliance for this citation.**	01/12/2017

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	an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect staff and up to 7 residents in the smoke compartment. Findings include: Based on observation with the Maintenance Director and the Administrator on 12/13/16 at 11:22 a.m., the 100 East corridor contained an alcove area which contained access for a hazardous room and a storage room. Furthermore, LSC 19.3.6.1(7) was not met because the room was not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of observation, the Maintenance Director and the Administrator acknowledged the aforementioned condition.		*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:** An electronically supervised automatic smoke detection system will be installed in the 100 East corridor alcove. **2) How the facility identified other residents:** A tour of the building was completed to identify any additional alcove areas that would require an additional electronically supervised automatic smoke detection system.	

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	3.1-19(b)		**3) Measures put into place/ System changes:** Maintenance staff educated on the requirements regarding electronically supervised automatic smoke detection systems in alcoves. An audit was devised to monitor for the presence of the appropriate smoke detection systems in alcoves. **4) How the corrective actions will be monitored:** An audit will be completed weekly by maintenance director or designee to monitor for the presence of electronically supervised automatic smoke detection systems in alcoves within the building. 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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			5) Date of compliance: **01/12/17**	
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 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 continuity of 3 of 3 100 hall attic smoke barriers in accordance with 8.5.2..2. LSC 8.5.2.2 states smoke barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. This deficient practice affects at least 29 residents as well as staff and visitors. Findings include: Based on observation with the	K 0372	**K372** **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*	01/12/2017

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	Maintenance Technician #1 on 12/13/16 between 8:41 a.m. and 12:30 p.m., the three 100 Hall attic smoke barriers only had access to one side of each barrier. The 100 East and 100 West smoke barriers had conduit running over the access panel providing little area to enter. No access panel was discovered for the north side of the 100 Hall North fire barrier. Based on interview at the time of observation, the Maintenance Technician #1 acknowledged each aforementioned condition and confirmed that he couldn't enter the attic areas with the conduit running over it to check the smoke barriers for continuity. 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:** 100 North hall has attic access. Attic access on 100 E. and 100 W. was adjusted to allow access without any conduit over the access opening. All attic smoke barriers have access to both sides of the smoke barrier. **2) How the facility identified other residents:** All other attic access points were checked to ensure that the access opening was unrestricted. All smoke barriers were checked to ensure that there was access to both sides of the barrier. **3) Measures put into place/**	

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			System changes: Maintenance was educated on the need for unrestricted access to the access panels as well as the need to be able to visualize both sides of the smoke barrier. An audit was devised to check attic access for unrestricted access as well as to check that access allows visualization of both sides of the smoke barriers. **4) How the corrective actions will be monitored:** An audit will be completed under the supervision of the maintenance director or designee on 4 attic access points weekly to determine if access is unrestricted. An audit will be completed by maintenance director or designee on two fire barriers per week to determine if both sides are able to be visualized. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or	

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			until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** **01/12/17**	
K 0511 SS=E 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. 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 1 300 Hall Dining room sink 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 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	K 0511	**K511** **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*	01/12/2017

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	subject to failure. This deficient practice could affect staff and 22 residents. Findings include: Based on observation with the Maintenance Director and the Administrator on 12/13/16 at 9:18 a.m., the 300 Hall Dining room had one GFCI receptacle within three feet of the hand 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 Maintenance Director and the Administrator acknowledged the aforementioned condition. 3.1-19(b)		*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 GFCI receptacle was replaced. **2) How the facility identified other residents:** All GFCI receptacles in the facility were checked with a GFCI tester to identify any additional outlets that were not functioning. **3) Measures put into place/ System changes:** Maintenance staff educated on the regulations regarding GFCI receptacles. An audit tool was devised to check GFCI receptacles for proper function. **4) How the corrective actions**	

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			will be monitored: An audit will be completed under the supervision of the maintenance director or designee on five GFCI receptacles per week to determine if the power in interrupted when the tester button is pressed. 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:** **01/12/17**	
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 18.5.2.2, 19.5.2.2 Based on observation and interview, the facility failed to install 3 of 3 Electric	K 0522	**K522**	01/12/2017

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	155156	A. BUILDING 01 B. WING	12/13/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Fireplaces in accordance with 19.5.2.2. LSC 19.5.2.2(1) any heating device shall have safety features to immediately shut down the equipment in case of either excessive temperature or ignition failure. This deficient practice could affect staff and up to 48 residents. Findings include: Based on observation with the Maintenance Director and the Administrator on 12/13/16 between 8:46 a.m. and, the following was discovered: a) Front Entrance electric fireplace b) 200 West Television area electric fireplace c) 400 West Lounge electric fireplace Based on interview at the time of each observation, the Maintenance Director and the Administrator confirmed that no documentation was available to prove the heating devices does not have anything installed to shut down the equipment in case of excessive temperature or ignition failure. 3.1-19(b)		**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 device which creates heat in the fireplaces will be disabled so that they are no longer a heat producing device. **2) How the facility identified other residents:** Other fireplaces within the facility	

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			were checked to determine if they produce heat. **3) Measures put into place/ System changes:** Maintenance staff educated on the safety requirements for devices which produce heat. An audit tool was devised to ensure that none of the fireplaces are heat producing. **4) How the corrective actions will be monitored:** Maintenance Director or designee will audit all fireplaces weekly to ensure that they remain unable to produce heat. 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:** **01/12/17**	
K 0711	NFPA 101			

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ARBORS AT MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

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SS=E Bldg. 01	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 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 19.7.2.2. 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) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect staff and up to 29 residents. Findings include:	K 0711	**K711** **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*	01/12/2017

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	Based on a record review with the Maintenance Director and the Administrator on 12/13/16 between 7:50 a.m. to 8:41 a.m., the facility provided information indicating locations of smoke/fire barriers. However, there were corridor doors that 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, the Administrator acknowledged the 300 Hall/ 400 Hall cross corridor doors did not have construction continuous in the attic. 3.1-19(b)		*federal and state law.* **1) Immediate actions taken for those residents identified:** Smoke barrier identification sheet was corrected to accurately identify smoke compartments and placed in all of the emergency and disaster preparedness manuals. **2) How the facility identified other residents:** All other smoke compartments were checked and correctly identified on the smoke compartment maps. **3) Measures put into place/ System changes:** In-serviced all staff on the location of the smoke compartment maps and the correct way to use the map to identify the next smoke compartment. An audit was created to test the staff understanding of smoke compartments and ability to correctly identify the next	

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			smoke compartment. **4) How the corrective actions will be monitored:** Maintenance Director or designee will audit five employees from various departments weekly on a variety of shifts on ability to identify smoke compartments and location of maps. 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:** **01/12/17**	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: * Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. * Decorations meet NFPA 701. * Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. * Decorations, such as photographs, paintings and other art are attached to the			

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	walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6. * The decorations in existing occupancies are in such limited quantities that a hazard of fire is not present. 18.7.5.6, 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 1 MDS office and 1 of 115 resident rooms were maintained in 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 49 residents. Findings include: Based on observations with the Maintenance Director and the Administrator on 12/13/16 at 10:22 a.m. then again at 10:34 a.m., the MDS office contained two candles with wicks. Then again, resident room 216 contained a candle with two wicks. Based on interview at the time of each observation, the Maintenance Director and the Administrator acknowledged each aforementioned condition. 3.1-19(b)	K 0753	**K753** **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:** All wicks were removed from the candle in the resident room. The candle was removed from the	01/12/2017

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			MDS office. **2) How the facility identified other residents:** The building was checked for additional candles in offices and resident rooms. **3) Measures put into place/ System changes:** A letter was provided to current residents and/or responsible parties educating them on the regulations regarding candles in resident rooms. The letter will be added to admission information for incoming residents. Staff was educated on the rules regarding candles in offices and in resident areas. An audit was devised to check for the presence of candles in both resident rooms and in offices. **4) How the corrective actions will be monitored:** An audit will be completed three times weekly under the supervision of the maintenance	

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			director or designee on three rooms and one office to monitor for the presence of candles. 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:** **01/12/17**	
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 wiring of a structure. Extension cords used			

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	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 Based on observation and interview, the facility failed to ensure 6 of 6 flexible cords were not used as a substitute for fixed wiring that provide a high current draw 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 70 residents in four smoke compartments. Findings include: Based on observation with the Maintenance Director and the Administrator on 12/13/16 between 8:50 a.m. and 11:32 a.m., the following was discovered: a) an extension cord was powering a microwave in the Restorative Nursing Services office b) a surge protector was powering a refrigerator in the 400 Hall Medication room	K 0920	**K920** **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) The microwave in the restorative nursing office was removed from a surge protector.	01/12/2017

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	c) a surge protector was powering an oxygen concentrator and a nebulizer in resident room 227 d) a surge protector was powering an oxygen concentrator in resident room 225 e) a surge protector was powering a refrigerator and air conditioner in the 200 Hall Assistant Director of Nursing office f) a surge protector was powering a microwave in the Community Services office Based on interview at the time of each observation, the Maintenance Supervisor and the Executive Director acknowledged each aforementioned condition. 3.1-19(b)		b) The surge protector was removed from the 400 Hall Medication Room. c) The oxygen concentrator and the nebulizer was removed from the surge protector in room 227. d) The oxygen concentrator was removed from the surge protector in room 225. e) The refrigerator and air conditioner were removed from the surge protector in the 200 hall ADON office. f) The microwave was removed from the surge protector in the Community Services office. **2) How the facility identified other residents:** All other offices and resident rooms were checked for the presence of high current draw items in surge protectors. **3) Measures put into place/ System changes:**	

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			A letter was provided to current residents and/or responsible parties educating them on the regulations regarding surge protectors in resident rooms. The letter will also be added to admission information provided to incoming residents. Staff was educated on the proper uses of surge protectors. An audit was devised to monitor for the use of surge protectors in resident rooms and in offices. **4) How the corrective actions will be monitored:** An audit will be completed three times weekly under the supervision of the maintenance director or designee on three rooms and one office to monitor for the presence of and proper use of surge protectors. 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:** **01/12/17**	

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K 0927 SS=D 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 oxygen transfill room was protected in accordance with 9.3.7.5.3.1. 2012 NFPA 99 9.3.7.5.3.1 requires oxygen transfill mechanical exhaust rooms to maintain a constant negative pressure. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director and the Administrator on 12/13/16 at 9:40 a.m., the 400 Hall oxygen transfill room fan was not running. The fan was checked with a piece of paper. Based on interview at the time of observation, the Maintenance Director and the	K 0927	**K927** **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*	01/12/2017

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	Administrator acknowledged the aforementioned condition. 3.1-19(b)		*and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Fan will be installed in the 400 oxygen transfill room. This practice could affect staff only. **2) How the facility identified other residents:** The fan in the 200 unit oxygen transfill room was checked, and the fan was functioning. This practice could affect staff only. **3) Measures put into place/ System changes:** Maintenance was educated on the method of checking the fans in the oxygen transfill rooms for constant negative pressure. An audit was devised to monitor for the function of the fans in the oxygen transfill rooms. **4) How the corrective actions**	

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			will be monitored: An audit will be completed three times weekly by the maintenance director or designee to test the functioning of the fans in the two oxygen transfill rooms. 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:** **01/12/17**	