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	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE ARBORS 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 Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 12/13/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/25/17 Facility Number: 000076 Provider Number: 155156 AIM Number: 100271060 At this Life Safety Code survey, Arbors at Michigan City was found in substantial 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	K 0000		

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	a capacity of 180 and had a census of 109 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/30/17 - DA			
K 0753 SS=B 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 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 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 10 residents.	K 0753	**K753** **The facility requests paper compliance for this citation.** *This Plan of Correction is*	02/24/2017

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	Findings include: Based on observations with the Director of Nursing and the Maintenance Assistant #1 on 01/25/17 at 12:16 p.m., resident room 216 contained a candle with a wick. Based on interview at the time of observation, the Director of Nursing and the Maintenance Assistant #1 acknowledged the aforementioned condition. 3.1-19(b) This deficiency was cited on 12/13/16. The facility failed to implement a systemic plan of correction to prevent recurrence.		*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. **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:**	

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			Residents will be reminded at each resident council meeting that they are not able to have candles with wicks in their rooms due to life safety regulations. They will also be informed at each meeting that staff will assist with the removal of wicks if they have/ receive a candle for their room. An audit was devised to check for the presence of candles in both resident rooms and in offices. Audit schedule for resident rooms was doubled to six rooms per week. **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 for six 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:**	

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K 0920 SS=A 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 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 1 of 1 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	K 0920	**K920** **The facility requests paper compliance for this citation.** *This Plan of Correction is*	02/24/2017

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	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 2 residents. Findings include: Based on observation with the Director of Nursing and the Maintenance Assistant #1 on 01/25/17 at 11:14 a.m., an extension cord was powering a microwave in the Restorative Nursing Services office. Based on interview at the time of observation, the Director of Nursing and the Maintenance Assistant #1 acknowledged the aforementioned condition. 3.1-19(b) This deficiency was cited on 12/13/16. The facility failed to implement a systemic plan of correction to prevent recurrence.		*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 refrigerator in the Restorative Nursing Services office was plugged directly into the wall. . **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.	

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			3) Measures put into place/ System changes: An audit was devised to monitor for the use of surge protectors in resident rooms and in offices. The number of rooms being audited was increased to three offices from one and will be completed three times weekly. Progressive discipline will be used for people in offices that do not comply with the regulation. **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 three offices 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:**	

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