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 _____	R **07/26/2022**

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 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 06/02/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/26/22 Facility Number: 000076 Provider Number: 155156 AIM Number: 100271060 At this PSR survey, Aperion Care Arbors at Michigan City was found 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 emergency generator. Resident rooms 301-312, which contain a non-operational 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 111.	{K 000}		

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
	155156	A. BUILDING **01** B. WING _____	R **07/26/2022**

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(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 000}	Continued From page 1 All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 07/27/22	{K 000}		