DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155481	A. BUILDING -- B. WING	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR TRACE HEALTH & LIVING COMMUNITY	3701 HODGIN RD RICHMOND, IN 47374

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/23/23 Facility Number: 000455 Provider Number: 155481 AIM Number: 100291010 At this Emergency Preparedness survey, Arbor Trace Health & Living Community was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 161 total beds. The healthcare portion of the facility has a capacity of 101 certified beds and had a census of 97 at the time of this visit. Quality Review completed on 03/27/23	E 0000	March 6, 2023 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: 36VB21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on March 23, 2023. This letter is to inform you that the plan of correction attached is to serve as Arbor Trace Health and Living credible allegation of compliance. We allege substantial compliance on April 1, 2023. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 765-939-3701. Sincerely, Shellie Ross, RN/HFA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Ross	RN/HFA	04/06/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			Administrator Arbor Trace Heath and Living Submission of this plan of correction in no way constitutes an admission by Arbor Trace Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State	K 0000	March 6, 2023	

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	Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/23/23 Facility Number: 000455 Provider Number: 155481 AIM Number: 100291010 At this Life Safety Code survey, Arbor Trace Health & Living Community 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 corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The 600 Hall and the Main Street Hall, which are assisted living areas of the facility, do not have the required fire resistance rated separation to be considered a separate occupancy. In addition, comprehensive care residents have customary access to the salon in the Main Street Hall. The facility has a capacity of 161 total beds. The healthcare portion of the facility has a capacity of 101 certified beds and had a census of 97 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached garage providing facility storage services which is not sprinklered.		Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: 36VB21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on March 23, 2023. This letter is to inform you that the plan of correction attached is to serve as Arbor Trace Health and Living credible allegation of compliance. We allege substantial compliance on April 1, 2023. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 765-939-3701. Sincerely, Shellie Ross, RN/HFA Administrator Arbor Trace Heath and Living	

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	Quality Review completed on 03/27/23		Submission of this plan of correction in no way constitutes an admission by Arbor Trace Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0222 SS=E Bldg. 02	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:			

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	CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.			

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	18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 1 of over 8 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1. (3) (4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 23 residents. Findings include: Based on the facility tour and interview with the Maintenance Director and Assistant Maintenance Director on 03/23/23 between 11:45 a.m. and 2:00 p.m., the exit door located in the service hall was provided with delayed egress locks but lacked the proper signage indicating the doors can be opened in 15 seconds by pushing on the door.	K 0222	**K 222** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The community failed to ensure that the service hall exit door has the proper delayed egress signage on it. The Maintenance Supervisor has posted the exit code on the keypad. See attached Picture labeled "Service Hall Signage" **II. The facility will identify other residents that may potentially be affected by the deficient practice.**	04/01/2023

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	Based on interview at the time of observation, the Maintenance Director acknowledged the door was equipped with a delayed egress and lacked the proper signage. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		All staff who use the service hall could have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The installation of the proper signage is a permanent fix and there is no follow up to this item. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Supervisor has been educated on the need to have the code and signage posted and CarDon Corporate Facilities will audit all door controls during their annual inspections. **V. Plan of Correction completion date.** Plan of Completion date is April 1st, 2023.	
K 0321 SS=E Bldg. 02	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating			

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	(with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. 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, 19.3.5.9 Area Automatic Sprinkler Separation 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) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	1. Based on observation and interview, the facility failed to maintain protection of 1 of 1 hot oil popcorn popper in the Cherished Memories activities area. This deficient practice could affect staff and up to 35 residents' staff and visitors. Findings include: Based on the facility tour and interview with the Maintenance Director and Assistant Maintenance	K 0321	**K 321** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The community	04/01/2023

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	Director on 03/23/23 between 11:45 a.m. and 2:00 p.m., a hot oil popcorn popper was being stored in the Cherished Memories activity area. When asked where the machine was used the activities director said it was used "right here." The aforementioned area is open to the corridor and did not have a door with a self-closing device installed. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 2. Based on observation and interview, the facility failed to ensure 2 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 residents, as well as staff and visitors in the DON office Suite. Findings include: Based on the facility tour and interview with the Maintenance Director and Assistant Maintenance Director on 03/23/23 between 11:45 a.m. and 2:00 p.m., the (1) Director of Nursing Suite (DON) greater than 50 square feet contained a number of combustible items, such as, paper, plastic, and 16 cardboard boxes. The corridor door to this office suite was did not self-close and latch into the door frame. Furthermore, (2) the kitchen storage room door, equipped with a self-closing device, failed so self-close and latch when tested more than three times. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance		failed to ensure that the DON office was kept debris and carboard free. The DON and Maintenance Supervisor has removed all the boxes from her office. See attached picture labeled “DON office” Observation 2- The community failed to ensure that the kitchen storage room door latched properly. The Maintenance Supervisor has adjusted the door so it will latch properly. See attached picture labeled “Kitchen storage room door” Observation 3- The community failed to ensure a popcorn machine was stored and used in an area not open to the corridor with a self-closing device installed. The popcorn machine has been removed from the facility. See attached picture labeled “Popcorn machine in activity area” **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents could have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic**	

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	Director and Executive Director present. 3.1-19(b)		**changes to ensure that the deficient practice does not recur.** A new Monthly TELS task has been created to inspect the DON office and other storage areas to ensure they are debris free, cooking devices are stored in an area not open to a corridor and the door latches to them. See attached TELS task labeled “Storage Area Inspection” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will monitor these areas to ensure they are debris free during their Site Visits. **V. Plan of Correction completion date.** Plan of Completion date is April 1st, 2023.	
K 0345 SS=C Bldg. 02	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,			

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	National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on records review and interview with the Maintenance Director and Executive Director on 03/23/23 between 9:45 a.m. and 11:45 p.m., no documentation could be provided regarding a visual semi-annual fire alarm system inspection. During the survey the maintenance Director searched for the missing documentation but was unable to locate any further documentation. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.	K 0345	**K 345** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – The community failed to provide the semiannual fire system inspection documentation for the last 12 months. The inspections took place on May 18th , 2022 and November 3rd, 2022. The community did not have a copy of the inspection reports to provide at the time of inspection. See attached inspection reports from Cintas Fire. The Maintenance Supervisor has placed copies of these in his life safety inspection binder for future review. See attached picture labeled “Fire Alarm and Signaling Inspection” **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Associates and Residents have the potential of being affected by this deficient practice.	04/01/2023

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	3.1-19(b)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current every 6 month fire panel system inspection TELS task to ensure these inspections take place. See attached TELS task labeled “Fire Panel Inspection” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will monitor these inspections to ensure they take place and the reports are placed in the life safety inspection binder. **V. Plan of Correction completion date.** Plan of Completion date is April 1st, 2023.	
K 0712 SS=C Bldg. 02	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying			

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	conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7			
	Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review and interview with the Maintenance Director and Executive Director on 03/23/23 between 9:45 a.m. and 11:45 p.m., 8 of 12 quarterly fire drills were conducted near the end of the month, around the 30th day of the month. These conditions do not allow fire drills to be conducted at unexpected and unpredictable days. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)	K 0712	**K 712** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – The Community Failed to ensure that their fire drills were conducted at unexpected and unpredictable times. The Maintenance Supervisor has been re educated on the frequency of fire drills and that they should occur at all times of the month, not always at the end. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the**	04/01/2023

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			deficient practice does not recur. There is currently a monthly TELS Task in place to conduct the 1st, 2nd, and 3rd shift fire drills. See attached TELS task Labeled "Fire Drills" **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Supervisor has been reeducated on the timeliness and frequency of fire drills. CarDon Corporate Facilities will monitor the fire drill logs to ensure that the frequency is correct and that they are being completed. **V. Plan of Correction completion date.** Plan of Completion date is April 1st, 2023.	
K 0920 SS=E Bldg. 02	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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155481	A. BUILDING 02 B. WING	03/23/2023

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	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. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 25 residents and staff in one smoke compartment. Findings include: Based on the facility tour and interview with the Maintenance Director and Assistant Maintenance Director on 03/23/23 between 11:45 a.m. and 2:00 p.m., in the attic above the Reevestone Hall, what appeared to be a heat tape was plugged into a green extension cord which was plugged into an outlet near the furnace. Based on interview at the time of observation, the Maintenance Supervisor acknowledged an extension cord was in use as described above and stated he thought it was likely powering a heat	K 0920	**K 920** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation #1- The Community failed to ensure that there we no improperly used extension cords or power strips within the community. The Maintenance Supervisor has removed the extension cord that was used to plug in heat tape in the attic. The heat tape is no longer needed so it will not be hard wired in. The Maintenance Supervisor has been educated that no extension cords are permitted within the community. See attached picture	04/01/2023

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	tape. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		labeled “extension cord” **II. The facility will identify other residents that may potentially be affected by the deficient practice.** The Maintenance staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** This is a permanent resolution, so no future follow up is needed. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will monitor the community to ensure there are no extension cords in use. **V. Plan of Correction completion date.** Plan of Completion date is April 1st, 2023.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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