

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155481	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 06/09/2014
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NAME OF PROVIDER OR SUPPLIER ARBOR TRACE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3701 HODGIN RD RICHMOND, IN 47374
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K020000	<p>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).</p> <p>Survey Date: 06/09/14</p> <p>Facility Number: 000455 Provider Number: 155481 AIM Number: 100291010</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>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 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinkled except for the areas cited in K-56. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors,</p>	K020000	<p>This plan of correction is to serve as Arbor Trace's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of survey allegations.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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K020025 SS=E	<p>and hard wired smoke detectors in all resident rooms. The healthcare portion of the facility has a capacity of 101 and had a census of 101 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled except resident rooms 308, 310, 316, 318, 407, 408, 409, 410, 411, 412, 413, 414, 104, 106, 108, 110, 120, 122, 124, 126, 227, 226, 228, 229 outside wall beyond the ceiling bulkhead and all areas providing facility services were sprinkled.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/10/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A</p>			

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	<p>minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 47 residents who use the main dining room located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation with assistant maintenance worker # 1 on 06/09/14 at 12:40 p.m., the kitchen ceiling above the automatic dish washer had a three foot by one foot rectangular area of drywall missing. Based on an interview with assistant maintenance worker # 1 on 06/09/14 at 12:45 p.m., a water line froze in the ceiling in February 2014 and the drywall has not been repaired. This was verified by assistant maintenance worker # 1 at the time of observation and acknowledged by the administrator at the exit conference on 06/09/14 at 1:00 p.m.</p> <p>3.1-19(b)</p>	K020025	<p>Smoke barriers are constructed to provide at least a one hour fire resistance rating. The three foot by one foot rectangular area missing drywall has been repaired with a 5/8 inch piece to fill the aforementioned space. To ensure no other residents were affected by the standard identified by the surveyor we completed a detailed inspection of our smoke barriers to establish proper compliance with this life safety code. Compliance of this code will be ensured during preventative maintenance checks identifying possible issues. A work order will be generated if an issue is found and the item will be resolved. This safety code will be revisited monthly as part of the quality assurance meeting. This will occur for the next three months and as needed thereafter. All changes will be completed by 7/9/2014</p>	07/09/2014			

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K020056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.</p> <p>Based on observation and interview, the facility failed to ensure 24 of 87 resident rooms were completely sprinkled. This deficient practice could affect 24 residents in the facility.</p> <p>Findings include:</p> <p>Based on observations on 06/09/14 during a tour of the facility with assistant maintenance worker # 1 from 9:30 a.m. to 1:00 p.m., resident rooms 308, 310, 316, and 318 had a two foot by twenty foot area on the outside wall of the rooms separated by a two foot wall extending down from the ceiling with no sprinkler</p>	K020056	<p>We have called US fire safety which is our vendor who maintains our sprinkler system. They will be in soon to add the sprinkler coverage to the identified rooms. To ensure no other residents were affected by the standard identified by the surveyor we checked all other rooms to establish that they were properly sprinklered. Compliance of this code will be ensured during preventative maintenance checks identifying possible issues. A work order will be generated if an issue is found and the item will be resolved. This safety code will be revisited monthly as part of the quality assurance meeting. This will</p>	07/09/2014
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	<p>coverage in the two foot by twenty foot area along the outside wall. Furthermore, resident rooms 407, 408, 409, 410, 411, 412, 413, 414, 104, 106, 108, 110, 120, 122, 124, 126, 227, 226, 228, and 229 had a two foot by thirteen too area on the outside wall of the rooms separated by a two foot wall extending down from the ceiling with no sprinkler coverage in the two foot by thirteen foot area along the outside wall. This was verified by assistant maintenance worker # 1 at the time of observations and acknowledged by administrator at the exit conference on 06/09/14 at 1:00 p.m.</p> <p>3.1-19(b)</p>		<p>occur for the next three months and as needed thereafter. All changes will be completed by 7/9/2014</p>				