

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155481	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/30/2015
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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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K 0000  Bldg. 02	<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: 07/30/15</p> <p>Facility Number: 000455 Provider Number: 155481 AIM Number: 100291010</p> <p>At this Life Safety Code survey, Arbor Trace Health &amp; 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. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and hard wired smoke detectors in all resident rooms. The healthcare portion of the facility has a capacity of 101 and</p>	K 0000	<p><b>Arbor Trace requests paper compliance for the following deficiencies. This plan of correction is to serve as ArborTrace'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 is 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 the survey allegations.</b></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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K 0018 SS=E Bldg. 02	<p>had a census of 101 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 doors to a resident service area protecting corridor openings did not have an impediment to the closing of the doors. This deficient practice could affect approximately 20 residents.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Regional Facility Manager and the Maintenance Supervisor on 07/30/15 at 11:00 a.m., the corridor door to the "Taste of Town" was equipped with a self closer and a device that released with the fire alarm. When the closing of the door was tested, the door would catch a high point on the</p>	K 0018	<p>I. Doors to the "Taste of Town" dining room have been repaired to resist the passage of smoke.</p> <p>II. The facility currently has no other doors not meeting guidelines for regulation K018.</p> <p>III. The systemic change includes monthly inspection of all facility doors by maintenance department personnel during fire drills. Any doors, if found to be affected by K018, will be repaired or replaced. A monthly inspection report will provided to the Administrator (or designee).</p> <p>IV. The Administrator (or designee) will audit the monthly door inspection report once each month for 3 months, then once every 3 months for a total of 12 months of monitoring. The results of the reports and monitoring will be discussed at the monthly Quality Assurance</p>	08/14/2015			

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K 0021 SS=F Bldg. 02	<p>floor causing the door not to close and latch into the frame. Based on interview during the time of observation, the Maintenance Supervisor acknowledged that the door was not closing due to the impediment of the floor.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 18.2.2.2.6 7.2.1.8.2</p> <p>Based on observation an interview, the facility failed to ensure 2 of 3 doors entering the kitchen open to the corridor would latch into the door frame. This deficient practice could affect any residents using facility's dining room and staff in the kitchen.</p> <p>Findings include:</p>	K 0021	<p>Committee meeting. Completion date: 8/14/2015</p> <p>I.The two doors entering the kitchen are self closing and will have automatic positive latching systems added. The vendor has ordered them so he will install once received</p> <p>II.The facility currently has no other doors not meeting guidelines for regulation K021.</p> <p>III.The systemic change includes monthly inspection of all facility</p>	08/28/2015

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K 0025 SS=E Bldg. 02	<p>Based on observation during the tour of the facility with the Regional Facility Manager and the Maintenance Supervisor on 07/30/15 at 10:54 a.m., two doors entering the kitchen from the dining room were swinging doors that did not latch into the door frame. The dining room did have self closing doors that latched into the frame but the wall separating the dining room from the corridor stopped 18 inches from the ceiling leaving the dining room and kitchen open to the corridor. Based on interview and telephone call at the time of observations, this was acknowledged by the Maintenance Supervisor.</p> <p>3.1-19(b)</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 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>doors by maintenance department personnel. Any doors, if found to be affected by K021, will be repaired. A monthly inspection report will be provided to the Administrator (or designee). IV.The Administrator (or designee) will audit the monthly door inspection report once each month for 3 months, then once every 3 months for a total of 12 months of monitoring. The results of the reports and monitoring will be discussed at the monthly Quality Assurance Committee meeting. Completion date: 8/28/2015</p>		

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	<p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 6 smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC Section 18.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 80 residents in 5 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Regional Facility Manager and the Maintenance Supervisor on 07/30/15 from 1:00 p.m. to 2:00 p.m., the following areas had unsealed penetrations through the smoke barrier walls:</p> <p>a) The smoke barrier wall located in Reeveston hall contained a one fourth inch gap around a pipe.</p> <p>b) The smoke barrier wall located in</p>	K 0025	<p>I. The three smoke barrier walls that had penetrations were sealed with 3m fire caulk. II. The facility currently has no smoke barrier walls not meeting guidelines for regulation K025.III. The systemic change includes inspection of all facility smoke barrier walls by maintenance department personnel after vendors have completed work. Any walls, if found to be affected by K25, will be repaired. IV. The Administrator (or designee) will follow up with maintenance after vendors leave to ensure smoke barriers were filled with 3m fire caulk if any penetrations were made during their work. Any issues will be discussed in our monthly QA meetings. Completion date: 8/14/2015</p>	08/14/2015			

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K 0027 SS=E Bldg. 02	<p>Henley hall contained an open one inch pipe with data cables running through it. c.) The smoke barrier wall located by the Parlor contained a one fourth inch gap around data wires.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors were equipped with rabbets, bevels, or astragals at the meeting edges. This deficient practice could affect 50 residents in 2 of 6 smoke</p>	K 0027	I. The one smoke barrier door that didn't have rabbets, bevels, or astragals was fixed by installing a brush guard to close the gap. II.The facility currently has no smoke barrier door not meeting guidelines for	08/14/2015

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K 0046 SS=F Bldg. 02	<p>compartments.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Regional Facility Manager and the Maintenance Supervisor on 07/30/15 at 12:54 p.m., the smoke barrier door set to the Reeveston hall was not equipped with rabbets, bevels, or astragals at the meeting edges of the doors. Based on interview during the time of observation, the Maintenance Supervisor acknowledged that the smoke barrier door was not equipped with rabbets, bevels, or astragals at the meeting edges of the door.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>Based on observation, and interview; the facility failed to ensure 9 of 9 emergency light fixtures throughout the facility were tested annually for 1½ hour duration and monthly for 30 second duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall</p>			K 0046	<p>regulation K027. III.The systemic change includes monthly inspection of all facility smoke barrier doors by maintenance department personnel during fire drills. Any walls, if found to be affected by K027, will be repaired. A monthly inspection report will provided to the Administrator (or designee). IV.The Administrator (or designee) will audit the monthly smoke barrier door inspection report once each month for 3 months, then once every 3 months for a total of 12 months of monitoring. The results of the reports and monitoring will be discussed at the monthly Quality Assurance Committee meeting. Completion date: 8/14/2015</p> <p>I. We have a computer program called TELS that lets us know what we need to test daily, weekly, monthly, quarterly and annually. We will add the testing of our emergency light fixtures monthly and annually to comply with regulation K046. In the mean time we will use a spreadsheet to document our</p>		08/14/2015

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	<p>be conducted on every required battery powered emergency lighting system for a minimum duration of 1 ½ hours and every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Regional Facility Manager and the Maintenance Supervisor on 07/30/15 at 10:49 a.m., emergency battery power lights were noted above the dining room exit and eight more throughout the facility. Based on interview at the time of observation, when ask if the emergency battery power lights are tested 30 seconds monthly, 90 minutes annually, and if the tests are documented, the Maintenance Supervisor stated the emergency battery powered are not tested for 30 seconds monthly, 90 minutes annually, or documented.</p> <p>3.1-19(b)</p>		<p>monthly and annual test of emergency light fixtures II. The facility has tested all 9 emergency light fixtures to meet the guidelines for regulation K046. III. The systemic change includes monthly and yearly inspection of all facility emergency light fixtures by maintenance department personnel. Any fixtures, if found to be affected by K046, will be repaired. A monthly inspection report will be provided to the Administrator (or designee). IV. The Administrator (or designee) will audit the monthly inspection report of our emergency light fixtures once each month for 3 months, then once every 3 months for a total of 12 months of monitoring. The results of the reports and monitoring will be discussed at the monthly Quality Assurance Committee meeting. Completion date: 8/14/2015</p>		

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K 0130 SS=E Bldg. 02	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 2 of 2 fire barrier walls separating health care from independent living was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts; cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the</p>	K 0130	<p>I.The two smoke barrier walls that had penetrations were sealed with 3m fire caulk. II.The facility currently has no smoke barrier walls not meeting guidelines for regulation K130. III.The systemic change includes inspection of all facility smoke barrier walls by maintenance department personnel after vendors have completed work. Any walls, if found to be affected by K130, will be repaired. IV.The Administrator (or designee) will follow up with maintenance after vendors leave to ensure smoke barriers were filled with 3m fire caulk if any penetrations were made during their work. Any issues will be discussed in our monthly QA meetings Completion date: 8/14/2015</p>	08/14/2015
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	<p>following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect 30 residents in 1 of 7 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with Regional Facility Manager and the Maintenance Supervisor on 07/30/15 between 1:17 p.m. to 1:33 p.m., the following was observed:</p> <p>(a) There were two half inch unsealed penetrations around data wires at the 700 hall fire barrier wall above the ceiling tiles.</p> <p>(b) There were two half inch unsealed penetrations around data wires at the 600 hall fire barrier wall above the ceiling tiles.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged and provided measurements of the penetrations.</p> <p>3.1-19(b)</p>			

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K 0143 SS=E Bldg. 02	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords in the beauty shop and 1 of 1 flexible cords in the marketing office were not used as a substitute for fixed wiring to provide power for equipment with a high current draw. NFPA 70, National Electrical Code, 1999 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 could affect 6 residents in the Beauty shop and staff in the marketing office.</p> <p>Findings include:</p> <p>Based on an observation during a tour of</p>	K 0143	<p>I. The cord in the beauty shop and marketing office were removed. II. The facility currently has no flexible cords in use to meet guidelines for regulation K143. III. The systemic change includes monthly inspection of all facility areas where flexible cords could be used by maintenance department personnel during their monthly environmental observations. Any cords found will be removed to comply with K143. A monthly inspection report will provided to the Administrator (or designee). IV. The Administrator (or designee) will audit the monthly inspection report for flexible cords once each month for 3 months, then once every 3 months for a total of 12 months of monitoring. The results of the</p>	08/14/2015	

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	the facility with Regional Facility Manager and the Maintenance Supervisor on 07/30/15 between 12:17 p.m. to 1:33 p.m., in the Beauty Shop, a hair dryer was supplied with electricity by an extension cord power strip. Also, in the marketing office, a refrigerator was supplied with electricity by an extension cord power strip. Based on interview, the Maintenance Supervisor acknowledged the power strips at the time of observation.  3.1-19(b)		reports and monitoring will be discussed at the monthly Quality Assurance Committee meeting. Completion date: 8/14/2015		