STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155481	A. BUILDING 00 B. WING	09/11/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for the Investigation of Nursing Home Complaints IN00416095 and IN00416500. Complaint IN00416095. No Nursing Home deficiencies related to the allegations are cited. State Residential deficiencies related to the allegations are cited at R0217 and R0240. Complaint IN00416500. No deficiencies related to the allegations are cited. Survey dates: September 7 and 11, 2023 Facility number: 000455 Provider number: 155481 AIM number: 100291010 Census Bed Type: SNF/NF: 82 SNF: 11 Residential: 31 Total: 124 Census Payor Type: Medicare: 20 Medicaid: 64 Other: 9 Total: 93 Arbor Trace Health and Living Community was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Nursing Home Investigation of Complaints IN00416095 and IN00416500. Quality review completed on September 14, 2023	F 0000	**This plan of correction is to serve as Arbor Trace Assisted Living's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Arbor Trace Assisted 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 and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **Arbor Trace respectfully requests a desk review for these deficiencies.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Ross	RN/HFA	09/22/2023

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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R 0000 Bldg. 00	This visit was for the Residential Investigation of Complaints IN00416095 and IN00416500. Complaint IN00416095. State deficiencies related to the allegations are cited at R0217 and R0240. No Nursing Home deficiencies related to the allegation were cited. Complaint IN00416500. No deficiencies related to the allegations are cited. Survey date: September 7 and 11, 2023 Facility number: 000455 Residential Census: 31 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	**This plan of correction is to serve as Arbor Trace Assisted Living's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Arbor Trace Assisted 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 and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **Arbor Trace respectfully requests a desk review for these deficiencies.**	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency;			

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	(C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to develop a service plan for 1 of 4 residents of being at risk for falls. (Resident J) Findings include: The clinical record for Resident J was reviewed on 9-7-23 at 4:45 p.m. Her diagnoses included, but were not limited to arthritis, weakness, unsteadiness on her feet and lack of coordination. A review of Resident J's recent progress notes indicated she had an unwitnessed fall on 7-7-23, in which the resident recalled she had tripped over her own feet and fell to her knee, but was unable to get herself up without assistance. There were no apparent injuries. In a review of Resident J's current service plans,	R 0217	**This plan of correction is to serve as Arbor Trace Assisted Living's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Arbor Trace Assisted 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 and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.**	09/26/2023

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	there was not a service plan to reflect her fall risk or recent fall. On 9-11-23 at 2:30 p.m., the Director of Nursing (DON) indicated she was unable to locate a current service plan for falls. On 9-11-23 at 2:30 p.m., the DON provided a copy of a procedure entitled, "Service Plan," with a revision date of May, 2012. This procedure indicated, "A service plan shall be developed after completion of the evaluation using appropriately trained staff members. This plan shall identify and document services to be provided by the facility." This Residential tag is related to Complaint IN00416095. 2.5-2(e)(1)(A) 2.5-2(e)(1)(B) 2.5-2(e)(1)(C) 2.5-2(e)(1)(D)		**Arbor Trace respectfully requests a desk review for these deficiencies.** **I. Resident J's medical record was reviewed during the survey and a fall service plan was added.** **II. All Assisted Living residents with a history of falls have the potential to be affected by the alleged deficient practice. All Assisted Living residents with falls in the past 30 days have been reviewed for a fall service plan. Any findings were corrected in the audit.** **III. Education was provided to the Assisted Living licensed nurse staff regarding fall assessments and development of fall service plans. The systemic change will include a review of the medical record for a fall service plan with any Assisted Living fall.** **IV. The DON/Designee will review all falls on Assisted Living for a fall service plan Monday through Friday with the Clinical Stand Up meeting. This audit will be completed daily Monday through Friday for 30 days then monthly for 11 months to total 12 months of auditing. Results of these**	

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			audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **R217 410 IAC 16.2-5-2€(1-5)Evaluation-Deficiency** **COMPLIANCE DATE: September 26, 2023**	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to ensure the call light system for the Assisted Living (AL) portion of the facility was monitored and responded to in a timely manner as evidenced by the pager for that system was muted and placed in a drawer at the nurse's station by the staff that was tasked with monitoring and responding to the AL portion of the facility during the early morning hours of 8-24-23. This had the potential to adversely affect all of the residents (estimated at 30 residents) on the AL unit of the facility. The deficient practice was corrected on 8-25-23, prior to the start of the survey, and was therefore past noncompliance. Findings include:	R 0240	**R240 410 IAC 16.2-5-4(d) Health Services-Deficiency** **The deficient practice was corrected on 8/25/2023 prior to the start of the survey, and was therefore past noncompliance. (Page 3 of 7 on 2567)** The deficient practice was corrected by 8/25/2023 after the facility implemented a systemic plan that included the following actions: initiation of an investigation related to untimely call light response, including but not limited to a review of the hall camera video of the staff involved,	09/26/2023

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	The facility submitted a reportable incident to the Indiana Department of Health's Long-Term Care Department on 8-24-23 regarding Resident G's call light not being answered in a timely manner. An interview on 9-11-23 at 6:30 a.m., with the Executive Director (ED), indicated in the early morning hours of 8-24-23, three staff members were responsible for responding to any call lights that were activated for the AL portion of the facility. The ED added the call light for Resident G, "was on for well over an hour. Each of them didn't exactly tell the truth when we interviewed them as to who did what versus what was witnessed on the [facility's hall camera] video." She shared the facility was provided a copy of a text message between CNA 2 and CNA 3, in which CNA 3 admitted he had muted the pager. The ED indicated a review of the camera video showed after CNA 3 had been holding the pager and placed it on the desk top, CNA 2 then placed the pager inside a drawer at the nurse's station. The ED included that at some point at or around this time, Resident G had a fall or slid onto the floor, "We can not determine exactly when, she slid onto the floor. It doesn't matter if it was at the beginning of when she put her call light on or after, the staff members did not go to check on her like they should have. So, we felt we were obligated to terminate each one of the ones involved. We cannot have staff here that does not perform up to our standards." In a written statement from LPN 5, dated 8-25-23, regarding her review of the hall camera video, she indicated she observed between 4:08 a.m. and 4:50 a.m. on 8-24-23, QMA 4 walked to the pager on the nurse's station desk and looked at, then left to go to the soiled utility room. She indicated CNA 3 picked up the pager, holding it for less than one		interviews with the staff involved, interviews with other residents regarding timeliness of call light response, review of the call light response times for Resident G, termination of the staff involved and staff education regarding facility expectations for staff, specific to call light response and customer service. (Page 7 of 7 2567)	

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	minute and then sat it back down, followed by CNA 2 picking up the pager and then placing it in a drawer at the nurse's station. In a written statement from the Assistant Director of Nursing (ADON), dated 8-25-23, regarding her observation of the hall camera video for the early morning hours of 8-24-23. It indicated the ADON observed QMA 4 "pick up the pager first due to pager alarming because a resident pendant had been pushed [activated]," followed by QMA 4 lying it back on the counter at the nurse's station. The pager was then picked up and viewed by CNA 2 and placed back on the desk at the nurse's station. Next, the statement indicated CNA 3 was observed to pick up the pager "and was noted to be pushing buttons on the pager and laid it back on the desk." The pager was then observed to be picked back up by CNA 2 and then placed in in a drawer at the nurse's station. On 9-11-23 at 11:00 a.m., the Director of Nursing (DON) and ED provided a copy of a document identifying the times and resident names of call light activation and response times for 8-24-23 for the AL portion of the facility. For Resident G, her call light was listed as having the following call light times activated and deactivated on 8-24-23: -activated at 2:13 a.m.; deactivated 2:16 a.m.; duration of 2+ minutes. -activated at 2:25 a.m.; deactivated 2:49 a.m.; duration of 14+ minutes. -activated at 4:39 a.m.; deactivated 6:01 a.m.; duration of 1 hour 21+ minutes. -activated at 6:05 a.m.; deactivated 6:11 a.m.; duration of 6+ minutes. -activated at 6:27 a.m.; deactivated 6:43 a.m.; duration of 15+ minutes. -activated at 8:29 a.m.; deactivated 8:35 a.m.; duration of 6+ minutes.			

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	Corresponding progress notes for Resident G indicated she had two unwitnessed falls on the morning of 8-24-23. The first fall indicated she was found on the floor at 6:12 a.m., in which the resident stated she slid off the couch and had no apparent injuries. The second note, timed for 9:29 a.m., indicated Resident G was found on the floor and was complaining of pain when trying to turn and left arm numbness. The notes reflected the Nurse Practitioner (NP) conducted a visit with Resident G and ordered for the resident to be sent to the local emergency room for further evaluation and treatment. In a subsequent interview with the DON on 9-11-23, she indicated Resident G passed away about 5 days after discharge from the facility. On 9-11-23 at 2:30 p.m., the DON provided a copy of a procedure entitled, "Emergency Care," with a revision date of May, 2012. It indicated, its purpose was "to assure adequate response to resident emergencies. Residents will receive appropriate emergency care and will have an emergency call system in their apartment unit...Prompt response to an activated call system will be provided 24-hours a day." The deficient practice was corrected by 8-25-23, after the facility implemented a systemic plan that included the following actions: initiation of an investigation, related to untimely call light response, including, but not limited to a review of the hall camera video of the staff involved, interviews with the staff involved, interviews with other residents regarding timeliness of call light response, review of the call light response times for Resident G, termination of the staff involved and staff education regarding facility expectations for staff, specific to call light response and			

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	customer service. This Residential tag is related to Complaint IN00416095. 2.5-4(d)			