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	09/14/2021

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

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/14/21 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 101 certified beds. At the time of the survey, the census was 93. Quality Review completed on 09/20/21	E 0000	Please find the enclosed Plan of Correction for the Life Safety Code Recertification and State Licensure Survey conducted on September 14, 2021. This plan of correction is to serve as Arbor Trace Health and Living's credible allegation of compliance. We allege substantial compliance on September 30, 2021. We are requesting paper compliance for this plan of correction. 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	Please find the enclosed Plan of	

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
	155481	A. BUILDING 02 B. WING	09/14/2021

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ARBOR TRACE HEALTH & LIVING COMMUNITY	3701 HODGIN RD RICHMOND, IN 47374

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	Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/14/21 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, 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 had a census of 93 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinkled except for one garage which was not sprinklered. Quality Review completed on 09/20/21		Correction for the Life Safety Code Recertification and State Licensure Survey conducted on September 14, 2021. This plan of correction is to serve as Arbor Trace Health and Living's credible allegation of compliance. We allege substantial compliance on September 30, 2021. We are requesting paper compliance for this plan of correction. 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 0353 SS=E Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems			

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	are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 areas observed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect all residents, visitors and staff. Findings include: Based on observation on 09/14/21 during the tour between 12:02 p.m. to 3:00 p.m. with the Maintenance Supervisor (MS), above the K cylinder in the Kitchen there was a sprinkler head missing an escutcheon. Based on interview at the time of observation, the MS confirmed the escutcheon was missing. This finding was reviewed with the Administrator during the exit conference.	K 0353	K353 Sprinkler System-Maintenance and Testing CFRs(s) NFPA 101 I. There were no residents affected by the alleged deficient practice. The escutcheon on the sprinkler head above the K cylinder in the kitchen has been replaced. II. All residents have the potential to be affected by the alleged deficient practice. All sprinkler heads have been reviewed and there were no other missing escutcheons. III. The systemic change includes the Maintenance director will audit sprinkler heads weekly to ensure escutcheons are in place on sprinkler heads. IV. There is a current Tels task in place to audit all	09/30/2021

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	3.1-19(b)		sprinkler heads weekly to ensure escutcheons are in place. V. Compliance date 9/30/2021	
K 0355 SS=B Bldg. 02	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers was properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect any staff. Findings include: Based on observation on 09/14/21 at 12:24 p.m. with the Maintenance Supervisor (MS), there was one abc portable fire extinguisher freestanding on the floor located in the Maintenance office on LTC hall. Based on interview concurrent with the observation it was confirmed by the MS the ABC portable fire extinguisher was full and not secured properly to prevent the cylinder from falling. This was discussed with the Administrator and ED during the exit conference. 3.1-19(b)	K 0355	K355 Portable Fire extinguishers CFR(s) NFPA 101 I. There were no residents affected by the alleged deficient practice. The portable fire extinguisher has been secured. II. All residents have the potential to be affected by the alleged deficient practice. All portable fire extinguishers have been reviewed and are properly secured. III. The systemic change includes the Maintenance Director will audit all portable fire extinguishers weekly to determine they are properly secured. IV. There is a current Tels task in place to audit all portable fire extinguishers weekly to ensure they are properly secured. V. Compliance date 9/30/2021	09/30/2021

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K 0372 SS=E Bldg. 02	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 5 smoke barriers observed had a minimum of a 1/2 hour fire resistive rating and the penetrations caused by the passage of wire and/or conduit the smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect 15 residents, visitors and staff. Findings include: Based on observation on 09/14/21 at 1:38 p.m. with the Maintenance Supervisor (MS), there were four wires penetrating the 300 smokewall through a one inch opening and was left unsealed. Based on interview after physical observation by the MS it was confirmed the penetration through the 300 smokewall was not firestopped to maintain a 1/2 hour fire resistive rating. This	K 0372	K372 Subdivision of Building Spaces- Smoke Barrier CFR(s) NFPA 101 I. There were no residents affected by the alleged deficient practice. The 300 smokewall has been firestopped. II. All residents have the potential to be affected by the alleged deficient practice. All smoke barrier walls have been inspected to determine there are no breeches in the walls. III. The systemic change includes if there is any maintenance work done on the smoke barrier walls, maintenance will verify no breech has occurred to the smoke barrier wall and correct any identified issues immediately. IV. There is a current	09/30/2021

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	finding was reviewed with the Administrator and MS during the exit conference 3.1-19(b)		Tels task in place to audit all smoke barrier walls for breeches weekly. V. Compliance date 9/30/2021	
K 0511 SS=E Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 wet locations observed was provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B) (1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors	K 0511	K511 Utilities-Gas and Electric CFR(s) NFPA 101 I. There were no residents affected by the alleged deficient practice. The GFCI next to the handsink in the kitchen has been replaced. II. All residents have the potential to be affected by the alleged deficient practice. All GFCIs have been checked to ensure they trip when tested. Any identified issues have been corrected. III. The systemic change includes the Maintenance Director will audit all GFCIs weekly to ensure they trip when tested. IV. There is a current Tels task in place to audit all GFCIs weekly to ensure they trip when tested.	09/30/2021

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	Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture		V. Compliance Date 9/30/2021	

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	can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff in the Biohazard room. Findings include: Based on observations on 09/14/21 at 12:53 p.m. with the Maintenance Supervisor (MS), there was a GFCI outlet next to the handsink in the Kitchen which when tested did not trip. Based on interview concurrent with the observation with the MS it was confirmed the GFCI was defective. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)			
K 0712 SS=F 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 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 verify transmission of the fire alarm signal for the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects	K 0712	K712 Fire Drills CFR(s)NFPA 101 I. There were no residents affected by the alleged deficient practice. II. All residents have the potential to be affected by the alleged deficient practice.	09/30/2021

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	all residents, staff and visitors. Findings include: Based on review of Monthly Fire Drill Reports on 09/14/21 at 11:13 a.m., with the Maintenance Supervisor (MS) there were no fire alarm drill reports available for review which documented the transmission of the fire alarm signal. Based on an interview with the MS at the time of record review, it was stated the transmission signal of the fire alarm to the monitoring station had not been documented for the past twelve months. This was reviewed with the Administrator during the exit conference. 3.1-19(b)		III. The systemic change includes the documentation form has been changed to have an area to document the transmission signal of the fire alarm to the monitoring station. IV. The Administrator/Designee will audit fire alarm documentation monthly (after each fire drill) to determine the transmission signal of the fire alarm to the monitoring station is completed and documented. V. Compliance date 9/30/2021	
K 0918 SS=C Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent			

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	personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on interview, the facility failed to ensure the fuel source for 1 of 1 emergency generator was from a reliable source. NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 5.1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all residents, staff and visitors.	K 0918	K918 Electrical Systems-Essential Electric System CFR(s): NFPA 101 I. There were no residents affected by the alleged deficient practice. The updated letter of reliability has been obtained. II. All residents have the potential to be affected by the alleged deficient practice. III. The systemic change includes the maintenance director will obtain an updated letter of reliability from the natural gas provider annually. IV. There is a current tells task in place to request an updated letter of reliability from the natural gas provider annually. V. Compliance date 9/30/2021	09/30/2021

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	Findings include: Based on interview and record review on 09/14/21 at 11:59 a.m. with the Maintenance Supervisor (MS), the fuel source for the emergency generator was natural gas with no other back up fuel source. Based on interview, the MS provided a letter of reliability from their natural gas provider, but it was dated 06/04/13. The MS was unaware the letter needed to updated periodically. This was discussed with the Administrator and MS during the exit conference. 3.1-19(b)			
K 0920 SS=B 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 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			

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	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 proper use of power strips in 1 of 1 areas observed. This deficient practice could affect up to 3 residents, visitors and staff. Findings include: Based on observations on 09/14/21 at 12:23 p.m. with the Maintenance Supervisor (MS), a power strip was used to power a coffee maker in the Maintenance office on LTC hall. Based on interview concurrent with the observation with the MS, it was acknowledged the power strip was improperly used. This finding was discussed with the Administrator and MS during the exit conference. 3.1-19(b)	K 0920	K920 Electrical Equipment- Power cords and extension cords CFR(s) NFPA 101 I. There were no residents affected by the alleged deficient practice. The extension cord was removed during the life safety survey. II. All residents have the potential to be affected by the alleged deficient practice. III. Education has been provided to the Maintenance Director regarding the use of extension cords. The systemic change includes no extension cords will be permitted for use in the maintenance office. IV. There is a current Tels task in place to audit all offices weekly to determine no extension cords are being used in an inappropriate manner V. Compliance date 9/30/2021	09/30/2021