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	06/04/2024

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: 06/04/24 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 92 at the time of this visit. Quality Review conducted on 06/05/24	E 0000		
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/04/24 Facility Number: 000455 Provider Number: 155481 AIM Number: 100291010	K 0000	June 21, 2024 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shelli Ross	RN/HFA	06/21/2024

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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	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 92 at the time of this visit. Quality Review conducted on 06/05/24		Re: Allegation of Compliance Event ID: 64N721 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on June 4, 2024. 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 July 19, 2024. 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	
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.			

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	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			
	1. Based on record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 1 of 1 automatic sprinkler piping systems that were internally inspected as required by NFPA 25, 2011 edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems in Chapter 14, Obstruction Prevention. Section 14.3.2 requires systems shall be examined for internal obstructions where conditions exist that could cause obstructed piping. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. Section 14.3.1 states if the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on records review and interview with the	K 0353	**K 353** **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 hydrostatic flush the was recommended by the provider was ever performed. The Maintenance Supervisor has contracted with Safecare to complete an entire flush of the sprinkler system starting the week of July 15th. See attached letter labeled "Arbor Trace Flush Letter." Observation 2- The community failed to ensure that the dry pipe sprinkler head in the freezer was debris and corrosion free. The Maintenance Supervisor has contracted with Safecare to	07/19/2024

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	Maintenance Director (MD) on 06/04/24 between 11:10 a.m. and 1:45 p.m., the Internal Pipe Inspection Letter from the facility's contractor dated 11/01/23 stated on 10/20/23 a 5-year internal pipe inspection was performed and revealed that the "branch lines were ½ full of hardened debris and could not be removed by hand." Also, "some sections of the grooved ends on the mains were partially missing from corrosion." Furthermore, the report stated that "we found that numerous amounts of the pipe did not have the correct pitch and were holding water. We suggest flushing the system to remove debris and to repatch the pipe and add additional low point drains to ensure all water is removed from the dry system." The aforementioned report also included pictures of the pipe obstructions. The MD stated that no work had been done on the sprinkler system to correct these issued and that they were waiting on a quote from the vendor, since November of 2023. The MD stated that he would begin immediately to seek another company to make the repairs and corrections recommended in the report. This finding was acknowledged by the MD at the time of discovery and again at the exit conference with the MD and Executive Director present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinklers in the freezer free of corrosion. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting		replace the sprinkler head. Safecare has measured the dry head and it is on order for replacement. Estimated install date is the week of July 1st. **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 changes to ensure that the deficient practice does not recur.** Observation 1- The Maintenance Supervisor has been re educated to ensure the recommendations from this inspection are completed. Observation 1- There is a current TELS task to have all sprinkler heads in the community visually inspected annually. See attached TELS work order labeled “Arbor Trace Visual Sprinkler Inspection.” **IV The facility will monitor the corrective action by implementing the following**	

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	unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 20 residents in one smoke compartment. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 06/04/24 between 1:15 p.m. and 3:15 p.m., the sprinkler head in the kitchen freezer had ice formed around it which covered the sprinkler head and was extending down approximately 2-3 inches forming an icicle. Based on interview at the time of observation, the MD agreed a sprinkler head in kitchen freezer was covered with ice. This finding was acknowledged by the MD at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		**measures.** CarDon Corporate Facilities will monitor these issues during their Site Visits and annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is July 19th, 2024.	
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.			

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	Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 15 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 06/04/24 between 1:15 p.m. and 3:15 p.m., the following corridor doors failed to latch positively into their respective door frames: a) The double set of doors leading into the	K 0363	**K 363** **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 double set of doors leading to the dining would shut and latch. The Maintenance Supervisor have reworked the set of doors to ensure they close and latch	07/19/2024

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	"Taste of Town" equipped with a self-closing device. b) The Employee Entrance corridor door, equipped with a self-closing device, did not have latching hardware and did not latch positively into the door frame. This finding was acknowledged by the MD at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		properly. Observation 2- The community failed to ensure that the employee hallway entrance door system did not have latching hardware. The Maintenance Supervisor has installed latching hardware on the door system. **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 changes to ensure that the deficient practice does not recur.** A Monthly TELS task has been created to inspect all corridor doors and fire doors to ensure they shut and latch properly. See attached TELS task labeled “Arbor Trace Door Inspection TELS Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will	

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			monitor these areas during their Site Visits and CQR. **V. Plan of Correction completion date.** Plan of Completion date is July 19th, 2024.	
K 0522 SS=E Bldg. 02	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry room was provided with intake combustion air from the outside for rooms containing fuel fired equipment. NFPA 101, Section 19.5.2.2(2) requires any fuel-fired heating device, other than a central heating plant, shall be designed and installed so they shall take air for combustion directly from the outside. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for 3 staff in the laundry room. Findings include:	K 0522	**K 522** **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 louvers for the dryer combustion air did not open and operate properly. The Maintenance Supervisor has	07/19/2024

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	Based on observations and interview during a tour of the facility with the Maintenance Director on 06/04/24 between 1:15 p.m. and 3:15 p.m., the laundry room had fuel fired dryers with an automatic louver system that would mechanically open when the dryers are running to provide air from the outside. The dryers were running at the time of observation, however the louvered vents were closed. The MD manually opened the vents to ensure they would open and stated they would need to be fixed to operate mechanically. This finding was acknowledged by the MD at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		replaced to damper motor. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Associates that work in the laundry room have the potential of being 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.** There is a newly created weekly TELS task to inspect the dryer dampers and louvers to ensure they are operating correctly. See attached TELS task labeled “Arbor Trace Dryer Inspection.” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect the dryer dampers and louvers during their site visits and annual CQR to ensure the operate correctly. **V. Plan of Correction**	

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			completion date. Plan of Completion date is July 19th, 2024.	