STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING -- B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/12/23 Facility Number: 002574 Provider Number: 155677 AIM Number: 201224380 At this Emergency Preparedness survey, Bell Trace Health & Living Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 90 certified beds. At the time of the survey, the census was 73. The requirements of 42 CFR, Subpart 483.73 is Not Met as evidenced by: Quality Review completed on 09/13/23	E 0000	September 27, 2023 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: 6S4321 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on September 12, 2023. This letter is to inform you that the plan of correction attached is to serve as Bell Trace Health & Living Community credible allegation of compliance. We allege substantial compliance on October 2nd, 2023. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 812-323-2858 Sincerely, Kelsey Haislip, HFA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelsey Haislip	HFA	09/28/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING -- B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
			Administrator Bell Trace Health and Living Submission of this plan of correction in no way constitutes an admission by Bell 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.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a),			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING -- B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	§485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated],			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING -- B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Disaster Preparedness plan on 09/12/23 between 9:44 a.m. and 12:55 p.m. with the Maintenance Supervisor present, the facility did provide an emergency preparedness manual, however, it has not been reviewed and updated during the past twelve months. The most recent date of review provided was 06/24/2022 on the Disaster Preparedness Program Review Log. Based on interview at the time of review, the Maintenance Supervisor said he knew the Disaster Preparedness Plan has been in the process of revision as evidence of documents being tabbed in the binder and agreed the plan presented had a revision date more than a year old. This finding was reviewed with the Maintenance Supervisor during the exit conference.	E 0004	**E 004** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that the emergency preparedness plan was reviewed and updated annually. The community leadership team has reviewed and updated the emergency preparedness plan. See attached scan showing the binder was updated with the proper names, titles, and dates. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents could 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 A- There is currently	09/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING -- B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
			an annual TELS task to have the emergency preparedness binder reviewed and updated. See attached TELS Task labeled "Emergency Preparedness TELS Task". **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will ensure that the Emergency Preparedness Binder has the proper documentation and updating during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is September 26, 2023.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING -- B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING -- B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the Disaster Preparedness plan on 09/12/23 between 9:44 a.m. and 12:55 p.m. with the Maintenance Supervisor present, the facility did provide an emergency preparedness manual, however, it has not been reviewed and updated during the past twelve months. The most recent date of review provided was 06/24/2022 on the Disaster Preparedness Program Review Log. Based on interview during records review, the Maintenance Supervisor stated the Policies and Procedures within the Disaster Preparedness Plan has been in the process of being updated and agreed the plan presented had a revision date	E 0013	**E 013** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that the emergency preparedness plan was reviewed and updated annually. The community leadership team has reviewed and updated the emergency preparedness plan. See attached scan showing the binder was updated with the proper names, titles, and dates. **II. The facility will identify**	09/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING -- B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	more than a year old. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		**other residents that may potentially be affected by the deficient practice.** All residents could 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 A- There is currently an annual TELS task to have the emergency preparedness binder reviewed and updated. See attached TELS Task labeled "Emergency Preparedness RELS Task". **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will ensure that the Emergency Preparedness Binder has the proper documentation and updating during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is September 26, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING -- B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Supervisor on 09/12/23 between 9:44 a.m. and 12:55 p.m., the Disaster Preparedness Plan had a date of 06/24/2022 on a document titled "Disaster Preparedness Program Review Log." No other date could be found to show the Disaster Preparedness plan's Communication Plan was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Supervisor stated that the Disaster Preparedness Plan was in the process of being updated by facility Administration.	E 0029	**E 029** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that the Emergency Preparedness Plan had an updated Communication Plan. The community leadership team has reviewed and updated the Communication Plan. See attached scan showing the Communication Plan was updated with the proper names, titles, and dates.	09/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING -- B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	This finding was reviewed with the Maintenance Supervisor during the exit conference.		**II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents could 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 A- There is currently an annual TELS task to have the emergency preparedness binder reviewed and updated. See attached TELS Task labeled "Emergency Preparedness TELS Task". **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will ensure that the Emergency Preparedness Binder has the proper documentation and updating during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING -- B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
			September 26, 2023.	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING -- B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	(a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed reviewed and updated the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all	E 0036	**E 036** **I. The corrective actions to be accomplished for those residents found to have been**	09/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING -- B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	occupants. Findings include: Based on records review with the Maintenance Supervisor on 09/12/23 between 9:44 a.m. and 12:55 p.m., the Disaster Preparedness Plan had a date of 06/24/2022 on a document titled "Disaster Preparedness Program Review Log." No other date could be found to show the Disaster Preparedness Plan's Training and Testing Plan was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Supervisor stated that the Disaster Preparedness Plan was in the process of being updated by the facility Administration. This finding was reviewed with the Maintenance Supervisor during the exit conference.		**affected by the deficient practice.** Observation A- The Community failed to ensure that the Emergency Preparedness Plan had an updated Communication Plan. The community leadership team has reviewed and updated the Communication Plan. See attached scan showing the Communication Plan was updated with the proper names, titles, and dates. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents could 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 A- There is currently an annual TELS task to have the emergency preparedness binder reviewed and updated. See attached TELS Task labeled “Emergency Preparedness TELS Task”.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING -- B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
			IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities will ensure that the Emergency Preparedness Binder has the proper documentation and updating during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is September 26, 2023.	
K 0000 Bldg. 01	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: 09/12/23 Facility Number: 002574 Provider Number: 155677 AIM Number: 201224380 At this Life Safety Code survey, Bell Trace Health and Living Center 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.	K 0000	September 27, 2023 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: 6S4321 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on September	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	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 hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 90 and had a census of 73 at the time of this survey. All areas where residents have customary access were sprinklered, and all areas providing facility services were sprinklered, except a wooden shed used for maintenance storage. Quality Review completed on 09/13/23		12, 2023. This letter is to inform you that the plan of correction attached is to serve as Bell Trace Health & Living Community credible allegation of compliance. We allege substantial compliance on October 2nd, 2023. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 812-323-2858 Sincerely, Kelsey Haislip, HFA Administrator Bell Trace Health and Living Submission of this plan of correction in no way constitutes an admission by Bell 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
			Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure the lighting for 2 of 7 exit means of egress was properly maintained and would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect at least 20 residents as well as staff and visitors. Findings include: Based on observations on 09/12/23 from 12:55 p.m. to 2:45 p.m. during a tour of the facility with the Maintenance Supervisor, the exit means of egress sidewalk from the end of Rehab Two that ran to the right for at least 150 feet until it reached a sidewalk to the public way was not equipped with any lighting. Additionally, the exit means of egress sidewalk out of the Main Dining did not have any lighting to the public way. Based on interview at the time of observation, the	K 0281	**K 281** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that the path of egress from the Rehab 2 exit door was illuminated to the public way. CarDon Corporate Facilities is contracting with All Pro Electric to add lighting along the 150ft pathway. This lighting will be hooked to the main back up generator at the community. **II. The facility will identify other residents that may potentially be affected by the**	10/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	Maintenance Supervisor agreed the sidewalks in the above mentioned areas were not equipped with any lighting. This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)		**deficient practice.** All residents and associates could 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 A- This is a permanent fix to this issue so no other follow-up will be needed. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect the path of egresses from the community during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is October 5th, 2023.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure all exits were equipped with emergency lighting in accordance with LSC 7.9. LSC 19.2.9.1 states emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. LSC 7.9.2.1 states emergency illumination shall be provided for a minimum of 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10.8 lux) and, at any point, not less than 0.1 ft-candle (1.1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (0.65 lux) at the end of 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. LSC 7.9.2.3 states the emergency lighting system shall be arranged to provide the required illumination automatically in the event of any interruption of normal lighting due to any of the following: (1) failure of a public utility or other outside electrical power supply (2) opening of a circuit breaker or fuse (3) manual act(s), including accidental opening of a switch controlling normal lighting facilities. This deficient practice could affect all residents, staff and visitors exiting the facility. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:55 p.m. to 2:45 p.m. on 09/12/23, there were lights outside the corridor exit of Rehab One. Based on interview at the time of observation, the Maintenance Supervisor stated he did not know if the lights were connected to emergency power as far as he knew. Further, the Maintenance Supervisor stated did not know if any of the lights outside of the facility exits were connected to	K 0291	**K 291** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to know if their exterior emergency lights were tied to the emergency generator. The Maintenance Supervisor and CarDon Corporate Facilities have tested these lights and verified that they are on an emergency electrical circuit. There are 3 circuits that feed power to the exterior lights. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and associates could 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 A- There is a semiannual TELS task to inspect all exterior lights to ensure proper	09/25/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	emergency generator power. This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)		operation. See attached Task labeled “Emergency Egress Lighting TELS Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect the path of egresses and lighting from the community during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is September 25, 2023.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 7 exits and directional sign was displayed in accordance with LSC 7.10. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shalt be marked by approved exit or directional exit signs where the continuation of the egress path is not	K 0293	**K 293** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	10/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	obvious. The deficient practice could affect at least 10 residents, staff and visitors using the main dining exit. Findings include: Based on observation on 09/12/23 at 2:35 p.m. during a tour of the facility with the Maintenance Supervisor, the exit from the main dining room discharges to a concrete patio area with a sidewalk going left or right along the backside of the building. There was no directional signage at the 'T' of the sidewalk to show which direction is to the public way. When asked which way is the exit on the sidewalk, the Maintenance Supervisor stated to the right, as taking the sidewalk to the left would deadend at the exit door by laundry. Based on interview at the time of observation, the Maintenance Supervisor agreed that egress path was not marked with directional exit sign arrows at the sidewalk outside the main dining room exit. This finding was reviewed with the Maintenance Supervisor at the exit conference. 3.1-19(b)		Observation A- The Community failed to ensure that the path of egress to the common way were marked with signage to direct residents and staff in the correct direction. The Maintenance Supervisor has ordered and will install directional signage along this pathway. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and associates could 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 A- This is a permanent solution to the citation so no follow up will be needed. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect the path of egresses and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
			signage from the community during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is October 5th, 2023.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 2 of 2 classroom/storage rooms with a large amount of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Supervisor on 09/12/23 during a tour of the facility from 12:55 p.m. to 2:45 p.m., the training room/conference room contained over 20 cardboard boxes of PPE supplies stacked on tables and was greater than 50 square feet making this a hazardous area. The room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Additionally, the classroom across from the main dining room contained a hot oil popcorn popper. The classroom corridor door did not have a self closing device installed. When asked where the popcorn popper is used, the Maintenance Supervisor stated popcorn is popped once in a while in the classroom where the popcorn popper is located. Based on interview at the time of each observation, the Maintenance Supervisor confirmed the training/conference room and classroom contained combustible storage and a hot oil popcorn popper, and the corridor doors to the rooms were not self-closing. These findings were reviewed with the Maintenance Supervisor at the exit conference. 3.1-19(b)	K 0321	**K 321** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that the training room and the classroom had the proper door closing devices on them. The Maintenance Supervisor has installed door closing devices on them. See attached pictures showing these devices. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and associates could 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 A- The installation of the door closing devices is a	09/28/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
			permanent fix so there is no follow up needed. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect these doors during their annual door inspection to ensure they are functioning properly. **V. Plan of Correction completion date.** Plan of Completion date is September 28th, 2023.	
K 0353 SS=E Bldg. 01	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. 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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure all sprinkler heads showing signs of corrosion were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states 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 unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect 10 residents and staff using the Therapy exit. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility at 1:47 p.m. on 09/12/23, the one sprinkler located outside of the Therapy Exit appeared green in color showing signs of corrosion. Based on interview at the time of observation, the Maintenance Supervisor confirmed the automatic sprinkler was green and showed signs of corrosion.	K 0353	**K 353** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that the dry sprinkler head above the therapy exit door was corrosion free. The Maintenance Supervisor has contacted Safecare to replace the sprinkler head. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and associates could 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 A- There is a new annual TELS task that was created to inspect all sprinkler heads to ensure that they are corrosion free. See attached TELS task labeled “Sprinkler Head Inspection”.	10/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	This finding was reviewed with the Maintenance Supervisor at the exit conference. 3.1-19(b)		**IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect all sprinkler heads within the community during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is October 5th, 2023.	
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall	K 0711	**K 711** **I. The corrective actions to be accomplished for those residents found to have been**	09/28/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches. (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants. Findings include: Based on review of "Fire Policies and Procedures" documentation located in the Disaster Preparedness binder with the Maintenance Supervisor from 9:44 a.m. to 12:55 p.m. on 09/12/23, the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observation with the Maintenance Supervisor during a tour of the facility from 12:44 p.m. to 2:45		**affected by the deficient practice.** Observation A- The Community failed to ensure that the fire safety plan addressed the removal of wheeled equipment during an emergency. The fire safety plan does address wheeled equipment and the Maintenance Supervisor was unaware of that part of the plan. Please see attached documents labeled “Fire Plan Documents”. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and associates could 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 A- The Maintenance Supervisor has been reeducated to make sure he addresses that all carts should be removed from the hallways during his new employee orientation. Also, the Administrator has addressed this during their morning stand up meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	p.m. on 09/12/23, wheelchairs and Hoyer lifts were stored in the corridors of the facility. Based on interview at the time record review and observation, the Maintenance Supervisor stated the facility removes wheeled equipment from the corridor during emergency drills but it could not be assured the written fire safety plan for the facility addressed the relocation of wheeled equipment during a fire or similar emergency. This finding was reviewed with the Maintenance Supervisor at the exit conference. 3.1-19(b)		**IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will ensure that the cart education is being addressed during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is September 28th, 2023.	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on records review, observation and interview; the facility failure to ensure 3 of 3 portable space heaters were not used in the facility and enforce the space heater policy. This deficient practice could affect at least 20 residents and staff in Skilled Two. Findings include: Based on record review with the Maintenance Supervisor on 09/12/23 at 12:50 p.m., the facility's space heater policy states "Bell Trace Health &	K 0781	**K 781** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure to keep space heater out of the community. An oil filled radiant heater was located	09/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	Living does not use portable space heaters in the facility." Based on observations during a tour of the facility with the Maintenance Supervisor on 09/12/23 from 12:55 p.m. to 2:45 p.m., the following was noted: a) an unplugged oil filled radiant portable space heater was located in the Skilled One nurse station. b) an oil filled radiant portable space heater observed in the Scheduler/Transportation office in Skilled Two was plugged in and in use. c) at 2:03 p.m., an oil filled radiant portable space heater observed in the Human Resources office was plugged in and in use. The door to this office was closed and locked and the staff had already gone home for the day according to the Maintenance Supervisor. The space heater was on it's highest setting and the 'Min-Max' dial was on Max. The back of the space heater was within three to four inches from two wooden two drawer filing cabinets which were very hot to the touch. The measurements were provided by the Maintenance Supervisor. This space heater was turned off and unplugged by the Maintenance Supervisor. Manufacturer's Instructions on the tag affixed to the power cord stated not to place the space heater within three feet of any furniture or draperies. Based on interview at the time of the observations, the Maintenance Supervisor confirmed three oil filled radiant space heaters were located in the facility and two of the three were being used. This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)		at the Skilled nurse station. Observation B- The Community failed to ensure to keep space heater out of the community. An oil filled radiant heater was in the transportation office. Observation C- The Community failed to ensure to keep space heater out of the community. An oil filled radiant heater was in the Human Resources Office. The Maintenance Supervisor removed these items from the community. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and associates could 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 A- The Maintenance Supervisor has reeducated all employees that portable radiant heaters are not permitted in the community. There is a new TELS task to inspect the community quarterly to look for and remove space heaters. See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
			TELS task labeled “Space Heater Inspection”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect and remove any portable heating devices during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is September 24th, 2023.	
K 0920 SS=B Bldg. 01	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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used 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 1 of 1 flexible cord was installed properly and used in a safe manner. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect approximately 6 residents and 4 staff in therapy. Findings include: Based on observation with the Maintenance Supervisor on 09/12/23 at 1:42 p.m., in the office area of Therapy, a power strip used to power equipment was not secured, and was dangling from the outlet on the wall under the counter. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observation, the Maintenance Supervisor agreed the power strip was dangling and placed it flat on the floor at the of observation. This finding was reviewed with the Maintenance Supervisor during the exit conference.	K 0920	**K 920** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that the power strip being used in the therapy office was securely attached to the wall or desk. The Maintenance Supervisor has attached the power strip to the wall. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and associates in the Therapy Gym could 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.**	09/28/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

(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
	3.1-19(b)		Observation A- The Maintenance Supervisor has been reeducated that all power strips located within the community need the proper UL listing and attached to the wall. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect all power strips within the community during their annual CQR to ensure they are the correct UL listing and attached to the wall. **V. Plan of Correction completion date.** Plan of Completion date is September 28th, 2023.	