PRINTED: 10/04/2023 ROVED 938-039

EPARTMENT OF HEALTH AND HUMAN SERVICES					
ENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 09		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED		

155677 B. WING 09/12/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 725 BELL TRACE CIRCLE BELL TRACE HEALTH AND LIVING CENTER **BLOOMINGTON, IN 47408** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE E 0000 Bldg. --An Emergency Preparedness Survey was E 0000 September 27, 2023 conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Brenda Buroker, Director Survey Date: 09/12/23 Long-Term Care Division Indiana State Department of Facility Number: 002574 Health Provider Number: 155677 2 North Meridian Street AIM Number: 201224380 Indianapolis, IN 46204 At this Emergency Preparedness survey, Bell Re: Allegation of Compliance Trace Health & Living Center was found not in compliance with Emergency Preparedness Event ID: 6S4321 Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR Dear Mrs. Buroker: 483.73. Please find enclosed the Plan of The facility has 90 certified beds. At the time of Correction for the State Licensure the survey, the census was 73. Survey conducted on September 12, 2023. This letter is to inform The requirements of 42 CFR, Subpart 483.73 is Not you that the plan of correction Met as evidenced by: attached is to serve as Bell Trace Health & Living Community Quality Review completed on 09/13/23 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

(X6) DATE

TITLE

HFA 09/28/2023 Kelsey Haislip

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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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			JILDING		COMPL			
		155677	B. W	ING		09/12	/2023	
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD			
					LL TRACE CIRCLE			
BELL TR	ACE HEALTH AND	LIVING CENTER		BLOOM	MINGTON, IN 47408			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE	
					Administrator			
					Bell Trace Health and Living			
					Submission of this plan of			
					correction in no way constitute			
					an admission by Bell Trace He			
					and Living or its management			
					company that the allegations contained in the survey report	ic o		
					true and accurate portrayal of			
					provision of nursing care or ot			
					services provided in this facility			
					The Plan of Correction is prep	-		
					and executed solely because			
					required by Federal and State			
					Law.			
					This statement of deficiencies			
					plan of correction will be review	wed		
					at the Monthly Quality			
					Assurance/Assessment Committee meeting.			
					Committee meeting.			
E 0004	403.748(a), 416.5	4(a), 418.113(a),						
SS=F	, ,	5(a), 483.475(a), 483.73(a),						
Bldg	484.102(a), 485.6	, ,						
	485.727(a), 485.9	20(a), 486.360(a),						
	491.12(a), 494.62							
		Review and Update						
	Annually							
	§403.748(a), §416	6.54(a), §418.113(a),						

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§441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a),

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i ´		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
155677		B. WING		09/12/2023		
	PROVIDER OR SUPPLIES		725 BE	ADDRESS, CITY, STATE, ZIP COD		
BELLIR	ACE HEALTH AND	LIVING CENTER	BLOOK	MINGTON, IN 47408		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	SIATE CONTINUE TO T	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	, ,, ,	625(a), §485.727(a), 6.360(a), §491.12(a),				
	The [facility] must	comply with all applicable				
		d local emergency				
		uirements. The [facility]				
	·	ablish and maintain a				
	•	mergency preparedness				
		ts the requirements of this				
		rgency preparedness				
	the following elem	lude, but not be limited to,				
	The following elem	ienis.				
	(a) Emergency Pla	an. The [facility] must				
		tain an emergency				
	•	n that must be [reviewed],				
	and updated at lea	ast every 2 years. The plan				
	must do all of the	following:				
	* [For hospitals at	§482.15 and CAHs at				
	-	ergency Plan. The [hospital				
	- , , -	nply with all applicable				
	_	id local emergency				
	preparedness req	uirements. The [hospital or				
	CAH] must develo	•				
		mergency preparedness				
		ts the requirements of this				
	section, utilizing a	n all-hazards approach.				
	* [For LTC Facilition	es at §483,73(a):1				
	_	The LTC facility must				
		tain an emergency				
	•	n that must be reviewed,				
	and updated at lea	ast annually.				
	* [For ESDD Essil	lities at §494.62(a):]				
	_	The ESRD facility must				
		tain an emergency				
	•	n that must be [evaluated],				

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155677		A. BU	JILDING	<u></u>	COMPL	ETED		
		B. W	NG		09/12/	2023		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	8		725 BE	LL TRACE CIRCLE			
BELL TR	ACE HEALTH AND	LIVING CENTER		BLOOM	/INGTON, IN 47408			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	and updated at lea	ast every 2 years.						
	Based on record reversal failed to develop and preparedness plant at least annually in 483.73(a). This defects residents in the facing Findings include: Based on review of plan on 09/12/23 betwith the Maintenant facility did provide manual, however, it updated during the recent date of review the Disaster Prepared Based on interview Maintenance Super Disaster Preparedness of revision being tabbed in the presented had a revold.	view and interview, the facility and maintain an emergency that was reviewed and updated accordance with 42 CFR ficient practice could affect all lity. The Disaster Preparedness etween 9:44 a.m. and 12:55 p.m. and the entergency preparedness that has not been reviewed and past twelve months. The most we provided was 06/24/2022 on edness Program Review Log. at the time of review, the visor said he knew the ess Plan has been in the as evidence of documents binder and agreed the plan ision date more than a year viewed with the Maintenance	E 00	004	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 plans was reviewed and updated annually. The community leadership team has reviewed updated the emergency preparedness plan. See attacked an showing the binder was updated with the proper name titles, and dates. II. The facility will identify other residents that may potentially be affected by the deficient practice. All residents could be affected this deficient practice. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.	ty and ched s,	09/26/2023	

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Observation A- There is currently

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155677	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/12/2023
	ROVIDER OR SUPPLIER		725 BE	ADDRESS, CITY, STATE, ZIP COD ELL TRACE CIRCLE MINGTON, IN 47408	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				an annual TELS task to have emergency preparedness bind reviewed and updated. See attached TELS Task labeled "Emergency Preparedness TE Task".	der
				IV The facility will monitor the corrective action by implementing the following measures.	
				CarDon Corporate Facilities we ensure that the Emergency Preparedness Binder has the proper documentation and updating during their annual CQR.	ill
				V. Plan of Correction completion date.	
				Plan of Completion date is September 26, 2023.	
E 0013 SS=F Bldg	484.102(b), 485.6. 485.727(b), 485.9. 491.12(b), 494.62 Development of E §403.748(b), §416. §441.184(b), §460. §483.73(b), §483. §485.68(b), §485. §485.920(b), §486. §494.62(b).	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 5.54(b), §418.113(b), 0.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 5.360(b), §491.12(b),			
	(b) Policies and pr	ocedures. [Facilities] must			

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am :		AID SERVICES	770)) (7	NAME AND ADDRESS OF THE PARTY O		1B NO. 0936-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CC	ONSTRUCTION	l ′	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING		COMP		
155677		B. WING		09/12	/2023	
	PROVIDER OR SUPPLIER		725 BE	ADDRESS, CITY, STATE, ZIP COD LL TRACE CIRCLE MINGTON, IN 47408		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	Į E	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
IAU	develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) of communication placetion. The polion be reviewed and users. *[For LTC facilities and procedures. The policy and imple preparedness polions.]	ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 s at §483.73(b):] Policies The LTC facility must ement emergency cies and procedures, based	IAU			DATE
	(a) of this section, paragraph (a)(1) communication placetion. The police be reviewed and the section of the section.	r plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must updated at least annually.				
	*[For PACE at §46 procedures. The develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) communication pl section. The polic address manager nonmedical emery limited to: Fire; eq failure; care-related disasters likely to safety of the partic	rements for PACE and 60.84(b):] Policies and PACE organization must ement emergency cies and procedures, based or plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must ment of medical and gencies, including, but not uipment, power, or water and emergencies; and natural threaten the health or cipants, staff, or the public. procedures must be				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING C			COMPI	LETED
		155677	B. WI	NG		09/12	/2023
	PROVIDER OR SUPPLIE	R D LIVING CENTER		725 BE	ADDRESS, CITY, STATE, ZIP COD LL TRACE CIRCLE MINGTON, IN 47408		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	T	ID	I		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1110		lated at least every 2 years.					BITTE
	*[For ESRD Facil and procedures. develop and imple preparedness pol on the emergency (a) of this section paragraph (a)(1) ocommunication ple section. The policible reviewed and years. These emenot limited to, fire failures, care-rela supply interruption likely to occur in the area. Based on record refailed to review and Preparedness Plants at least annually in 483.73(a). This defoccupants. Findings include: Based on review of plan on 09/12/23 be with the Maintenar facility did provide manual, however, in updated during the recent date of review the Disaster Prepare Based on interview Maintenance Super Procedures within thas been in the pro-	ities at §494.62(b):] Policies The dialysis facility must ement emergency icies and procedures, based y plan set forth in paragraph , risk assessment at of this section, and the lan at paragraph (c) of this cies and procedures must updated at least every 2 ergencies include, but are , equipment or power ted emergencies, water n, and natural disasters he facility's geographic view and interview, the facility d update the Emergency is (EPP) Policies and Procedures accordance with 42 CFR ficient practice could affect all of the Disaster Preparedness etween 9:44 a.m. and 12:55 p.m. he Supervisor present, the e an emergency preparedness t has not been reviewed and past twelve months. The most is we provided was 06/24/2022 on edness Program Review Log. In during records review, the revisor stated the Policies and the Disaster Preparedness Plan cess of being updated and sented had a revision date	E 00	013	E 013 I. The corrective actions to accomplished for those residents found to have bee affected by the deficient practice. Observation A- The Commun failed to ensure that the emergency preparedness plar was reviewed and updated annually. The community leadership team has reviewed updated the emergency preparedness plan. See attated scan showing the binder was updated with the proper name titles, and dates. II. The facility will identify	n ity n d and ched	09/26/2023

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155677	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION (X3) DATE SURVEY COMPLETED 09/12/2023
	PROVIDER OR SUPPLIER		725 BE	ADDRESS, CITY, STATE, ZIP COD ELL TRACE CIRCLE MINGTON, IN 47408	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
	more than a year old. This finding was reviewed with the Administrator and Maintenance Director during the exit		other residents that may potentially be affected by the deficient practice.		
	conference.	nector during the exit		All residents could be affected this deficient practice.	by
				III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.	c
				Observation A- There is curren an annual TELS task to have the mergency preparedness binder reviewed and updated. See attached TELS Task labeled "Emergency Preparedness REITask".	ne er
				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	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155677		X2) MULTIPLE CONSTRUCTION X. A. BUILDING B. WING			X3) DATE SURVEY COMPLETED 09/12/2023	
	PROVIDER OR SUPPLIER		72	REET ADDRESS, CITY, STATE, ZIP (25 BELL TRACE CIRCLE LOOMINGTON, IN 47408	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREF TA	FIX PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
E 0029 SS=F Bldg	484.102(c), 485.6: 485.727(c), 485.9: 491.12(c), 494.62: Development of C §403.748(c), §416: §441.184(c), §466: §483.73(c), §485.9: §485.68(c), §485.9: §494.62(c). (c) The [facility] m an emergency preplan that complies local laws and mu at least every 2 years facilities]. Based on record review and updat Preparedness Plan's least annually in acceptants. Findings include: Based on records results and service of 06/24/2022. Preparedness Progradate of 06/24/2022. Preparedness Plan's reviewed and updat on an interview dur Maintenance Supersister of the service of the se	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 485.68(c), 20(c), 486.360(c), (c) communication Plan 5.54(c), §418.113(c), 2.84(c), §482.15(c), 475(c), §484.102(c), 5.25(c), §485.727(c), 5.360(c), §491.12(c), 2.360(c), 2.360(c	E 0029	E 029 I. The corrective acti accomplished for the residents found to ha affected by the defici practice. Observation A- The C failed to ensure that the Emergency Preparedrice had an updated Comment Plan. The community team has reviewed and the Communication Plantached scan showing Communication	ommunity ne ness Plan munication leadership id updated lan. See g the was updated	09/26/2023

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155677	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION (X3) DATE SURVEY COMPLETED 09/12/2023
	PROVIDER OR SUPPLIEF		725 BE	ADDRESS, CITY, STATE, ZIP COD ELL TRACE CIRCLE MINGTON, IN 47408	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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 re Supervisor during t	viewed with the Maintenance he exit conference.		II. The facility will identify other residents that may potentially be affected by the deficient practice.	
				All residents could be affected this deficient practice.	by
				III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.	c
				Observation A- There is current an annual TELS task to have the emergency preparedness binder reviewed and updated. See attached TELS Task labeled "Emergency Preparedness TELTask".	ne er
				IV The facility will monitor the corrective action by implementing the following measures.	
				CarDon Corporate Facilities wil ensure that the Emergency Preparedness Binder has the proper documentation and updating during their annual CO	
				V. Plan of Correction completion date.	
				Plan of Completion date is	

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EPARTMENT OF HEALTH AND HUN	FORM APPROVED			
ENTERS FOR MEDICARE & MEDICA	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
	155677	B. WI	NG	09/12/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER			725 BELL TRACE CIRCLE	
BELL TRACE HEALTH AND LIVING CENTER			BLOOMINGTON IN 47408	

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED 09/12/2023	
		155677	B. WING			
NAME OF F	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD		
BELL TR	ACE HEALTH AND	LIVING CENTER	BLOO	MINGTON, IN 47408		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		on, policies and procedures				
		of this section, and the				
		an at paragraph (c) of this				
		ing and testing program				
		and updated at least				
	annually.					
	*IFor ICE/IIDo of 8	3492 475(d):1 Training and				
		§483.475(d):] Training and ID must develop and				
		gency preparedness training				
		am that is based on the				
		et forth in paragraph (a) of				
		issessment at paragraph				
		on, policies and procedures				
	. , , ,	of this section, and the				
		an at paragraph (c) of this				
		ing and testing program				
		and updated at least every				
	2 years. The ICF/					
	1 -	evacuation drills and training				
	at §483.470(i).	-				
	*[For ESRD Facili	ties at §494.62(d):]				
		and orientation. The				
	1 -	ıst develop and maintain an				
		redness training, testing				
	· ·	ation program that is based				
		plan set forth in paragraph				
	l ` '	risk assessment at				
	1	of this section, policies and				
		agraph (b) of this section,				
		cation plan at paragraph (c)				
		ne training, testing and				
		m must be evaluated and				
	updated at every		F 0026		00/26/2022	
		view and interview, the facility	E 0036	E 036	09/26/2023	
		l updated the Emergency			.	
	_	s (EPP) Training and Testing		I. The corrective actions to	be	
		ly in accordance with 42 CFR		accomplished for those		
	483./3(a). This def	ficient practice could affect all		residents found to have bee	n	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155677	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/12/2023
	PROVIDER OR SUPPLIEF		725 BE	ADDRESS, CITY, STATE, ZIP COD LL TRACE CIRCLE MINGTON, IN 47408	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	REGULATORY OF occupants. Findings include: Based on records re Supervisor on 09/12 12:55 p.m., the Dist date of 06/24/2022 Preparedness Progr date could be found Preparedness Plan's was reviewed and u Based on an intervi Maintenance Super Preparedness Plan supdated by the facility	eview with the Maintenance 2/23 between 9:44 a.m. and aster Preparedness Plan had a on a document titled "Disaster am Review Log." No other to show the Disaster Training and Testing Plan pdated within the last year. ew during records review, the visor stated that the Disaster was in the process of being ity Administration.		affected by the deficient practice. Observation A- The Commun failed to ensure that the Emergency Preparedness Planad an updated Communication Plan. The community leaders team has reviewed and updated the Communication Plan. Seattached scan showing the Communication Plan was upowith the proper names, titles, dates. II. The facility will identify other residents that may potentially be affected by the deficient practice. All residents could be affected this deficient practice. III. The facility will put into place the following systemat changes to ensure that the deficient practice does not recur. Observation A- There is curred.	ity an don ship ded dee dated and d by ttic
				an annual TELS task to have emergency preparedness bin reviewed and updated. See attached TELS Task labeled "Emergency Preparedness Ti Task".	der

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155677		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 09/12/2023			
	PROVIDER OR SUPPLIE	R LIVING CENTER	725 E	ET ADDRESS, CITY, STATE, ZIP COD BELL TRACE CIRCLE OMINGTON, IN 47408	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				IV The facility will monitor the corrective action by implementing the following measures.	
				CarDon Corporate Facilities we ensure that the Emergency Preparedness Binder has the proper documentation and updating during their annual CQR.	vill
				V. Plan of Correction completion date. Plan of Completion date is September 26, 2023.	
K 0000				GOPTOTTIBOT 20, 2020.	
Bldg. 01	Licensure Survey v	Recertification and State was conducted by the Indiana lth in accordance with 42 CFR	K 0000	September 27, 2023	
	483.90(a). Survey Date: 09/1:			Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health	
	Facility Number: (Provider Number: AIM Number: 201	155677		2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Complian	nce
	and Living Center with Requirements	-		Event ID: 6S4321	
	Life Safety from Fi National Fire Prote Life Safety Code (I	I, 42 CFR Subpart 483.90(a), re and the 2012 Edition of the ction Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2.		Dear Mrs. Buroker: Please find enclosed the Plan Correction for the State Licen: Survey conducted on Septem	sure

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	OF CORRECTION	IDENTIFICATION NUMBER 155677	A. BUILDING B. WING	01	COMPLETED 09/12/2023
	PROVIDER OR SUPPLIER		725 BE	ADDRESS, CITY, STATE, ZIP COD ELL TRACE CIRCLE MINGTON, IN 47408	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Type V (111) constr sprinklered. The fact with hard wired smot spaces open to the c sleeping rooms. The and had a census of All areas where resilied were sprinklered, and	-		12, 2023. This letter is to informate you that the plan of correction attached is to serve as Bell Tr. Health & Living Community credible allegation of complian We allege substantial complian on October 2nd, 2023. We arrequesting paper compliance this plan of correction. If you have any further question please do not hesitate to contain at 812-323-2858 Sincerely, Kelsey Haislip, HFA Administrator Bell Trace Health and Living	ace nce. nce e for
				Submission of this plan of correction in no way constitute an admission by Bell Trace He and Living or its management company that the allegations contained in the survey report true and accurate portrayal of provision of nursing care or ot services provided in this facilit The Plan of Correction is prep and executed solely because required by Federal and State	is a the her y. ared it is

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10/04/2023 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155677 B. WING 09/12/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 725 BELL TRACE CIRCLE BELL TRACE HEALTH AND LIVING CENTER **BLOOMINGTON. IN 47408** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting. K 0281 **NFPA 101** SS=E Illumination of Means of Egress Bldg. 01 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 K 281 K 0281 10/05/2023 failed to ensure the lighting for 2 of 7 exit means of egress was properly maintained and would not I. The corrective actions to be leave the area in darkness. LSC 7.8.1.4 requires accomplished for those illumination shall be arranged so that that the residents found to have been failure of any single lighting unit does not result affected by the deficient in an illumination level of less than 0.2 foot-candle practice. in any designated area. This deficient practice could affect at least 20 residents as well as staff Observation A- The Community and visitors. failed to ensure that the path of egress from the Rehab 2 exit door Findings include: was illuminated to the public way. CarDon Corporate Facilities is Based on observations on 09/12/23 from 12:55 contracting with All Pro Electric to p.m. to 2:45 p.m. during a tour of the facility with add lighting along the 150ft the Maintenance Supervisor, the exit means of pathway. This lighting will be egress sidewalk from the end of Rehab Two that hooked to the main back up ran to the right for at least 150 feet until it reached generator at the community. a sidewalk to the public way was not equipped

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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

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II. The facility will identify

potentially be affected by the

other residents that may

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	OF CORRECTION	IDENTIFICATION NUMBER 155677	A. BUILDING B. WING	01	COMPLETED 09/12/2023
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE AP	(X5) COMPLETION DATE
	the above mentioned with any lighting.	visor agreed the sidewalks in d areas were not equipped viewed with the Maintenance ne exit conference.		deficient practice. All residents and associates of the affected by this deficient practice.	could
	3.1-19(b)			III. The facility will put into place the following systema changes to ensure that the deficient practice does not recur.	tic
				Observation A- This is a permanent fix to this issue so other follow-up will be needed	i.
				IV The facility will monitor the corrective action by implementing the following measures.	
				CarDon Corporate Facilities v inspect the path of egresses f the community during their ar CQR.	rom
				V. Plan of Correction completion date.	
				Plan of Completion date is October 5th, 2023.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lightir Emergency Lightir Emergency lightin duration is provide accordance with 7	ng g of at least 1-1/2-hour d automatically in			

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155677	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/12/2023	
	OF PROVIDER OR SUPPLIED TRACE HEALTH AND			725 BE	ADDRESS, CITY, STATE, ZIP COD LL TRACE CIRCLE MINGTON, IN 47408		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	failed to ensure all emergency lighting LSC 19.2.9.1 states 1/2 hour duration is accordance with 7.9 illumination shall be 1/2 hours in the even Emergency lighting provide initial illumination less than 0.1 ft-along the path of expelling the path of expelling illumination levels not less than an average of 1 1/2 lillumination unifor exceeded. LSC 7.9 lighting system share quired illumination of the following: (1) foutside electrical points.	on and interview, the facility exits were equipped with in accordance with LSC 7.9. The emergency lighting of at least 1 is provided automatically in 2. LSC 7.9.2.1 states emergency is provided for a minimum of 1 is ent of failure of normal lighting. It facilities shall be arranged to mination that is not less than an alle (10.8 lux) and, at any point, candle (1.1 lux), measured gress at floor level. Is shall be permitted to decline to grage of 0.6 ft-candle (0.65 lux) mours. A maximum-to-minimum mity ratio of 40 to 1 shall not be 2.3 states the emergency ill be arranged to provide the on automatically in the event of normal lighting due to any of a failure of a public utility or other ower supply (2) opening of a size (3) manual act(s), including	K 0	291	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Observation A- The Communificated to know if their exterior emergency lights were tied to emergency generator. The Maintenance Supervisor and CarDon Corporate Facilities hat 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.	ty the ave	09/25/2023
	accidental opening lighting facilities. 'affect all residents, facility. Based on observations Supervisor during a p.m. to 2:45 p.m. o outside the corridor interview at the time Maintenance Super the lights were confar as he knew. Fur Supervisor stated designations of the supervisor stated designation of the supervisor stated designation.	of a switch controlling normal This deficient practice could staff and visitors exiting the ons with the Maintenance a tour of the facility from 12:55 in 09/12/23, there were lights exit of Rehab One. Based on e of observation, the visor stated he did not know if enected to emergency power as either, the Maintenance id not know if any of the lights ty exits were connected to			All residents and associates of 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 inspall exterior lights to ensure productions.	ic ect	

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	OF CORRECTION	IDENTIFICATION NUMBER 155677	A. BUILDING B. WING	01	COMPLETED 09/12/2023
	ROVIDER OR SUPPLIER		725 BE	ADDRESS, CITY, STATE, ZIP COD LL TRACE CIRCLE MINGTON, IN 47408	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	This finding was rev Supervisor during th	viewed with the Maintenance		operation. See attached Task labeled "Emergency Egress Lighting TELS Task"	
	3.1-19(b)			IV The facility will monitor the corrective action by implementing the following measures.	
				CarDon Corporate Facilities we inspect the path of egresses a lighting from the community detection their annual CQR.	ind
				V. Plan of Correction completion date.	
				Plan of Completion date is September 25, 2023.	
K 0293 SS=E Bldg. 01	accordance with 7 illumination also se lighting system. 19.2.10.1 (Indicate N/A in on occupancies with I	al signs are displayed in .10 with continuous erved by the emergency ne-story existing ess than 30 occupants exit travel is obvious.)			
	Based on observation failed to ensure 1 of was displayed in acc 7.10.1.2.2 states hor egress path within a marked by approved	on and interview, the facility 7 exits and directional sign cordance with LSC 7.10. LSC rizontal components of the n exit enclosure shalt be d exit or directional exit signs ion of the egress path is not	K 0293	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.	

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155677	A. BUI B. WIN	LDING	01	COMPLETED 09/12/2023	
		155677	b. WIN	_		09/12/2023	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
 REII TE	PACE HEALTH AND	D LIVING CENTER			ELL TRACE CIRCLE MINGTON, IN 47408		
	TOL HEALTH AND	D LIVING CENTER			1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	``	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
TAG		ient practice could affect at		TAG		DATE	
		staff and visitors using the			Observation A- The Communi	itv	
	main dining exit.	5			failed to ensure that the path of	•	
					egress to the common way we		
	Findings include:				marked with signage to direct		
		00/10/02 + 0.05			residents and staff in the corre	ect	
		ion on 09/12/23 at 2:35 p.m. e facility with the Maintenance			direction. The Maintenance	.:11	
	_	t from the main dining room			Supervisor has ordered and w install directional signage alon		
	_	acrete patio area with a			this pathway.	9	
		t or right along the backside of					
	_	e was no directional signage at			II. The facility will identify		
		ralk to show which direction is			other residents that may		
		When asked which way is the			potentially be affected by the)	
		k, the Maintenance Supervisor			deficient practice.		
	_	as taking the sidewalk to the lat the exit door by laundry.			All residents and associates c	ould	
		at the time of observation, the			be affected by this deficient	odid	
		rvisor agreed that egress path			practice.		
	was not marked wi	th directional exit sign arrows at			l ·		
	the sidewalk outside	le the main dining room exit.					
					III. The facility will put into		
	Supervisor at the e	eviewed with the Maintenance			place the following systemat	ic	
	Supervisor at the e	xit conference.			changes to ensure that the deficient practice does not		
	3.1-19(b)				recur.		
					Observation A- This is a		
					permanent solution to the cita		
					so no follow up will be needed	1.	
					IV The facility will monitor		
					the corrective action by		
					implementing the following		
					measures.		
					Company Comments 5 199	.au	
					CarDon Corporate Facilities w		

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	OF CORRECTION	IDENTIFICATION NUMBER 155677	A. BUILDING B. WING	01	COMPLETED 09/12/2023
	ROVIDER OR SUPPLIER		725 BE	ADDRESS, CITY, STATE, ZIP COD ELL TRACE CIRCLE MINGTON, IN 47408	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE 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	barrier having 1-hd (with 3/4 hour fire automatic fire extir accordance with 8 approved automat option is used, the from other spaces partitions and door Doors shall be self automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fuelb. Laundries (large c. Repair, Mainten	reprotected by a fire our fire resistance rating rated doors) or an anguishing system in areas shall be separated by smoke resisting rating rational resisting or and permitted to have pplied protective plates that inches from the bottom of			
	e. Trash Collection				

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NAMI OF PROVIDER OR SLIPPI IR BELL TRACE HEALTH AND LIVING CENTER SITREET ADDRESS, CITY, STATE, ZIP COD 725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408 SITREET ADDRESS, CITY, STATE, ZIP COD 725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408 SITREET ADDRESS, CITY, STATE, ZIP COD 725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408 SITREET ADDRESS, CITY, STATE, ZIP COD 725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408 SITREET ADDRESS, CITY, STATE, ZIP COD 725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408 SITREET ADDRESS, CITY, STATE, ZIP COD 725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408 SITREET ADDRESS, CITY, STATE, ZIP COD 725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408 SITREET ADDRESS, CITY, STATE, ZIP COD 725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408 SITREET ADDRESS, CITY, STATE, ZIP COD 725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408 SOME C	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) N		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
STREET ADDRESS, CITY, STATE, JIP COD 725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408 SUMMARY STATIMENT OF DEFICIENCE REFEX (RACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYMEN DEFORMATION I. 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 hoxes of PPE supplies stacked on tables and was greater than 50 square feet making this a hazardous area. The room was not self-closing or automatic closing. Additionally, the classroom across from the main dining room contained a lot oil popeorm popper. The classroom orridor door did not have a self closing device installed. When asked where the popeor popper is located. Based on interview at the time of each observation, the Maintenance Supervisor confirmed the training/conference room and classroom contained on bustible storage and a hot oil popeorm popper; and the corridor doors to the rooms were not self-closing. These findings were reviewed with the	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
EBELL TRACE HEALTH AND LIVING CENTER IXA ID SUMMARY STATEMENT OF DEFICIENCE (IACH DEFICIENCY MUST BE PRECEDED BY ULL TAG REGULATORY OR LSC IDENTIFYING NFORMATION 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 finiled 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 stucked 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 dimig room contained a hot oil oppoern popper. The classroom corridor door did not have a self closing device installed. When asked where the propeen popper is iseed, the Maintenance Supervisor stated popcorn is popped once in a while in the classroom where the proper on poper is located. Based on interview at the time of each observation, the Maintenance Supervisor confirmed the training conforence room and elassroom contained the training conforence room and elassroom contained a hot oil popcorn popper; the classroom where the popcorn popper; to located. Based on interview at the time of each observation, the Maintenance Supervisor confirmed the training conforence room and elassroom contained combustible storage and a hot oil popcorn popper; and the corridor doors to the rooms were not self-closing.			155677	B. W	ING		09/12/	2023
BELL TRACE HEALTH AND LIVING CENTER BELL TRACE HEALTH AND LIVING CENTER SIMMARY STATEMENT OF DEFICIENCY REGULATORY OR LISC IDENTIFYING INFORMATION TAG SIMMARY STATEMENT OF DEFICIENCY REGULATORY OR LISC IDENTIFYING INFORMATION REGULATORY OR LISC IDENTIFYING INFORMATION TAG REGULATORY OR LISC IDENTIFY TAG REGULATORY OR LISC IDENTIFY TAG REGULATORY					STREET	ADDRESS, CITY, STATE, ZIP COD		
BELL TRACE HEALTH AND LIVING CENTER IXAI D SUMMARY STATEMENT OF DEFICIENCE (IACTI DEPICIORY WORT BY PLEEDED BY PULL TAG 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 field 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 cardshaard 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 specification; proper door closing devices on them. See attached pictures showing these devices. II. The facility will identify other residents than 4 supported one in a while in the classroom where the popeom popper. The classroom corridor door did not have a self closing device installed. When asked where the popeom popper is located. Based on interview at the time of each observation, the Maintenance Supervisor confirmed the training/conference room and classroom contained a hot oil popeom popper is located. Based on interview at the time of each observation, the Maintenance Supervisor confirmed the training confirmed the confirmed the confirmed the confirmed the calculation of the facility of the residents that may potentially be affected by the deficient	NAME OF F	PROVIDER OR SUPPLIEF	8					
Oxional Display Disp	BELL TR	ACE HEALTH AND	LIVING CENTER					
### RECULATORY OR LISC IDENTIFYING INFORMATION 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: Description of the facility from 12:55 pm. 02:45 pm., 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 popcom popper is used, the Maintenance Supervisor contirmed the training/conference room and classroom contained combustible storage and a hot oil popcom popper, and the corridor doors to the rooms were not self-closing. The facility will identify other residents that may potentially be 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. See attached pictures showing these devices. II. The facility will identify other residents that may potentially be affected by the deficient practice. III. The facility will identify other residents that may potentially be affected by the deficient practice. III. The facility will put into place the following systematic changes to ensure that the deficient practice. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not received.		T				1		
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3.1-19(b) the door closing devices is a		3.1-19(b)					•.	

PRINTED: 10/04/2023 FORM APPROVED OMB NO. 0938-039

PROVIDER OR SUPPLIER				09/12/2023
ACE HEALTH AND			ADDRESS, CITY, STATE, ZIP COD ELL TRACE CIRCLE	
	LIVING CENTER		MINGTON, IN 47408	
		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
· ·		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
			permanent fix so there is no fo up needed.	llow
			IV The facility will monitor the corrective action by implementing the following measures.	
			CarDon Corporate Facilities wi inspect these doors during the annual door inspection to ensu they are functioning properly.	ir
			V. Plan of Correction completion date.	
			Plan of Completion date is September 28th, 2023.	
Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an a) Date sprinkler b) Who provided c) Water system Provide in REMAR	Maintenance and Testing or and standpipe systems sed, and maintained in IFPA 25, Standard for the grand Maintaining of Protection Systems. In design, maintenance, sting are maintained in a dreadily available. System last checked system test supply source			
	NFPA 101 Sprinkler System - Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any r	NFPA 101 Sprinkler System - Maintenance and Testing 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	NFPA 101 Sprinkler System - Maintenance and Testing 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	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG PREFI

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î ´			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			COMPLETED	
		155677	B. WI	NG		09/12/2023
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD	
					LL TRACE CIRCLE	
BELL TR	RACE HEALTH AND	LIVING CENTER		BLOOM	MINGTON, IN 47408	
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	9.7.5, 9.7.7, 9.7.8	•	17.0	2.52	1, 0.50	10/05/2022
		on and interview, the facility	K 0	353	K 353	10/05/2023
		sprinkler heads showing signs eplaced in accordance with			I The compative actions to I	
		25, Standard for the Inspection,			I. The corrective actions to I accomplished for those	De
		enance of Water-Based Fire			residents found to have been	_
	_	, 2011 Edition, Section 5.2.1.1.1			affected by the deficient	
	•	all not show signs of leakage;			practice.	
	•	rosion, foreign materials, paint,			p. 2011001	
		ge; and shall be installed in the			Observation A- The Communi	itv
		(e.g., up-right, pendent, or			failed to ensure that the dry	
		nore, at 5.2.1.1.2 any sprinkler			sprinkler head above the thera	ару
	· ·	any of the following shall be			exit door was corrosion free.	• •
	replaced:	•			Maintenance Supervisor has	
	(1) Leakage				contacted Safecare to replace	the
	(2) Corrosion				sprinkler head.	
	(3) Physical Damag					
	1 1	the glass bulb heat responsive			II. The facility will identify	
	element				other residents that may	
	(5) Loading				potentially be affected by the	9
	(6) Painting unless manufacturer.	painted by the sprinkler			deficient practice.	
	, ,	sprinklers that are loaded with			All residents and associates of	ould
	_	to clean sprinklers with			be affected by this deficient	
	_	y a vacuum provided that the		practice.		
		touch the sprinkler.				
	_	ice could affect 10 residents				
	and staff using the	Therapy exit.			III. The facility will put into	
	T' 1' ' 1 1				place the following systematic	tic
	Findings include:				changes to ensure that the	
	Rosed on observation	on with the Maintenance			deficient practice does not	
		on with the Maintenance tour of the facility at 1:47 p.m.			recur.	
		e sprinkler located outside of			Observation A- There is a new	v
		opeared green in color showing			annual TELS task that was	v
		Based on interview at the time			created to inspect all sprinkler	
		Maintenance Supervisor			heads to ensure that they are	
	· ·	matic sprinkler was green and			corrosion free. See attached	
	showed signs of con				TELS task labeled "Sprinkler I	Head
	g 11 6 0.				Inspection".	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155677		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(x3) date survey COMPLETED 09/12/2023	
	ROVIDER OR SUPPLIER		725 BE	ADDRESS, CITY, STATE, ZIP COD ELL TRACE CIRCLE MINGTON, IN 47408	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	This finding was results Supervisor at the example of the supervisor at the su	viewed with the Maintenance it conference.		IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities w inspect all sprinkler heads with the community during their and CQR. V. Plan of Correction completion date. Plan of Completion date is October 5th, 2023.	nin
K 0711 SS=C Bldg. 01	patients and for the of an emergency. Employees are per kept informed with and a copy of the with telephone opplan addresses the of staff per 18/19.7 of the fire safety per 18/19.2.2. 18.7.1.1 through 18.7.2.2, 18.7.2.3, 19.7.2.1.2, 19.7.2.1.2, 19.7.2.1.2, 19.7.2.1.2. Based on record revinterview; the facility plan that addressed written fire plans. In	elocation Plan plan for the protection of all eir evacuation in the event riodically instructed and their duties under the plan, plan is readily available erator or with security. The e basic response required 7.2.1.2 and provides for all lan components per 8.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3,	K 0711	K 711 I. The corrective actions to be accomplished for those residents found to have beer	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01	COMPLETED	
155677 B. WING	09/12/2023	
100077 E. WING	09/12/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD		
725 BELL TRACE CIRCLE		
BELL TRACE HEALTH AND LIVING CENTER BLOOMINGTON, IN 47408		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE	
provide for the following: affected by the deficient		
(1) Use of alarms practice.		
(2) Transmission of alarm to fire department		
(3) Emergency phone call to fire department Observation A- The Communi	itv	
(4) Response to alarms failed to ensure that the fire sa	-	
(5) Isolation of fire plan addressed the removal or	-	
(6) Evacuation of immediate area wheeled equipment during an		
(7) Evacuation of smoke compartment emergency. The fire safety pl		
(8) Preparation of floors and building for does address wheeled equipm		
evacuation and the Maintenance Supervise		
(9) Extinguishment of fire was unaware of that part of the		
Section 19.2.3.4(4) Projections into the required plan. Please see attached		
width shall be permitted for wheeled equipment, documents labeled "Fire Plan"		
provided that all of the following conditions are Documents".		
met:		
(a) The wheeled equipment does not reduce the		
clear unobstructed corridor width to less than 60 other residents that may		
inches. potentially be affected by the	_	
(b) The health care occupancy fire safety plan and deficient practice.		
training program address the relocation of the		
wheeled equipment during a fire or similar All residents and associates or	buld	
emergency.	louid	
(c) The wheeled equipment is limited to the practice.		
following:		
i. Equipment in use and carts in use		
ii. Medical emergency equipment not in use		
iii. Patient lift and transport equipment place the following systemat	tic	
This deficient practice could affect all occupants. Changes to ensure that the		
deficient practice does not		
Findings include: recur.		
Based on review of "Fire Policies and Procedures" Observation A- The Maintenar	nce	
documentation located in the Disaster Supervisor has been reeducated in the Disaster	ted to	
Preparedness binder with the Maintenance make sure he addresses that		
Supervisor from 9:44 a.m. to 12:55 p.m. on carts should be removed from	the	
09/12/23, the written fire safety plan did not hallways during his new emplo	oyee	
address the relocation of wheeled equipment orientation. Also, the	-	
during a fire or similar emergency. Based on Administrator has addressed t	this	
observation with the Maintenance Supervisor during their morning stand up		

during a tour of the facility from 12:44 p.m. to 2:45

meeting.

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU			COMPL	LETED
155677		B. WING 09/12/2023			/2023		
NAME OF PROMISES OF CURBINES				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				725 BE	LL TRACE CIRCLE		
BELL TR	ACE HEALTH AND	LIVING CENTER		BLOOM	/INGTON, IN 47408		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	wheelchairs and Hoyer lifts were					
		ors of the facility. Based on			IV The facility will monitor		
	interview at the time record review and observation, the Maintenance Supervisor stated the facility removes wheeled equipment from the			IV The facility will monitor the corrective action by			
	-	ergency drills but it could not			implementing the following measures.		
	_	en fire safety plan for the			measures.		
		ne relocation of wheeled			CarDon Corporate Facilities w	/ill	
	•	fire or similar emergency.			ensure that the cart education		
	-1				being addressed during their	.0	
	This finding was re	viewed with the Maintenance			annual CQR.		
		at the exit conference.					
	•				V. Plan of Correction		
3.1-19(b)				completion date.			
					Plan of Completion date is		
					September 28th, 2023.		
K 0781	NFPA 101						
SS=E	Portable Space H						
Bldg. 01	Portable Space H						
		eating devices shall be					
	•	ealth care occupancies,					
	· ·	ed in nonsleeping staff and where the heating elements					
		2 degrees Fahrenheit (100					
	degrees Celsius).						
	18.7.8, 19.7.8						
		eview, observation and	K 0	781	K 781		09/24/2023
		ity failure to ensure 3 of 3	110	701			07/21/2023
		ers were not used in the			I. The corrective actions to b	эе	
		the space heater policy. This			accomplished for those		
		ould affect at least 20 residents			residents found to have been	n	
	and staff in Skilled	Two.			affected by the deficient		
					practice.		
	Findings include:						
					Observation A- The Communi	ty	
	Based on record rev	view with the Maintenance			failed to ensure to keep space		
	Supervisor on 09/12	2/23 at 12:50 p.m., the facility's			heater out of the community.	An	
	space heater policy	states "Bell Trace Health &			oil filled radiant heater was loc	rated	İ

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/12/2023 155677 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 725 BELL TRACE CIRCLE BELL TRACE HEALTH AND LIVING CENTER **BLOOMINGTON, IN 47408** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Living does not use portable space heaters in the at the Skilled nurse station. facility." Based on observations during a tour of Observation B- The Community the facility with the Maintenance Supervisor on failed to ensure to keep space 09/12/23 from 12:55 p.m. to 2:45 p.m., the following heater out of the community. An was noted: oil filled radiant heater was in the a) an unplugged oil filled radiant portable space transportation office. heater was located in the Skilled One nurse Observation C- The Community failed to ensure to keep space b) an oil filled radiant portable space heater heater out of the community. An observed in the Scheduler/Transportation office oil filled radiant heater was in the in Skilled Two was plugged in and in use. Human Resources Office. c) at 2:03 p.m., an oil filled radiant portable space heater observed in the Human Resources office The Maintenance Supervisor was plugged in and in use. The door to this office removed these items from the was closed and locked and the staff had already community. gone home for the day according to the Maintenance Supervisor. The space heater was II. The facility will identify on it's highest setting and the 'Min-Max' dial was other residents that may on Max. The back of the space heater was within potentially be affected by the three to four inches from two wooden two drawer deficient practice. filing cabinets which were very hot to the touch. The measurements were provided by the All residents and associates could Maintenance Supervisor. This space heater was be affected by this deficient turned off and unplugged by the Maintenance practice. 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 III. The facility will put into or draperies. place the following systematic Based on interview at the time of the changes to ensure that the observations, the Maintenance Supervisor deficient practice does not confirmed three oil filled radiant space heaters recur. were located in the facility and two of the three Observation A- The Maintenance were being used. Supervisor has reeducated all This finding was reviewed with the Maintenance employees that portable radiant Supervisor during the exit conference. heaters are not permitted in the community. There is a new TELS 3.1-19(b) task to inspect the community quarterly to look for and remove space heaters. See attached

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AND PLAN OF CORRECTION IDENT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155677	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/12/2023	
NAME OF PROVIDER OR SUPPLIER BELL TRACE HEALTH AND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
				TELS task labeled "Space Hell Inspection".	ater	
				IV The facility will monitor the corrective action by implementing the following measures.		
				CarDon Corporate Facilities w inspect and remove any porta heating devices during their at CQR.	ble	
				V. Plan of Correction completion date.		
				Plan of Completion date is September 24th, 2023.		
K 0920 SS=B Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by qua the conditions of the patient care vi non-PCREE (e.g. except in long-term do not use PCRE meet UL 1363A of for non-PCREE in (outside of vicinity non-patient care r	ent - Power Cords and ent - Power Cords and coatient care vicinity are only ents of movable ed electrical equipment les that have been alified personnel and meet 10.2.3.6. Power strips in cinity may not be used for a personal electronics), m care resident rooms that E. Power strips for PCREE or UL 60601-1. Power strips the patient care rooms b) meet UL 1363. In cooms, power strips meet ls. All power strips are				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155677		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 09/12/2023		
NAME OF PROVIDER OR SUPPLIER BELL TRACE HEALTH AND LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	cords are not used wiring of a structul temporarily are relicompletion of the installed and meet 10.2.3.6 (NFPA 99 (NFPA 70), 590.3 (Based on observation failed to ensure 1 of properly and used in Section 10.2.4.2 state cords meeting the rest through 10.2.4.2.3 states the 10.2.3. Section 10.2 shall be provided at cord to the appliance either pull, twist, or internal connections could affect approximate in the property of the provided at cord to the appliance of the provided at cord to the appliance of the pull, twist, or internal connections could affect approximate the pull, twist, or internal connections could affect approximate the pull, twist, or internal connections could affect approximate the pull, twist, or internal connections could affect approximate the pull area of Therapy, a prequipment was not a from the outlet on the condition could put causing damage to the interview at the time. Maintenance Superwas dangling and plof observation.	precautions. Extension d as a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was as the conditions of 10.2.4. 20), 10.2.4 (NFPA 99), 400-8 20) (NFPA 70), TIA 12-5 21) and interview, the facility of a safe manner. NFPA 99, tes adapters and extension equirements of 10.2.4.2.1 22) thall be permitted. Section exabling shall comply with 2.3.5.1 states cord strain relief the attachment of the power es that mechanical stress, bend, is not transmitted to as. This deficient practice imately 6 residents and 4 staff 22) at 1:42 p.m., in the office power strip used to power secured, and was dangling the wall under the counter. This stress on the power cord the power cord. Based on the of observation, the visor agreed the power strip laced it flat on the floor at the viewed with the Maintenance the exit conference.	K 0920	I. The corrective actions to accomplished for those residents found to have bee affected by the deficient practice. Observation A- The Commun failed to ensure that the power strip being used in the therap office was securely attached 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 Therapy Gym could be affected this deficient practice. III. The facility will put into place the following system and changes to ensure that the deficient practice does not recur.	ity er y to e e n the ed by	

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Ì		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155677	X2) MULTIPLE CONSTRUCTION A. BUILDING D1 B. WING		(X3) DATE SURVEY COMPLETED 09/12/2023		
NAME OF PROVIDER OR SUPPLIER BELL TRACE HEALTH AND LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 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
mo	3.1-19(b)			TAG	Observation A- The Maintenal Supervisor has been reeducated that all power strip 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 winspect all power strips within	os I	BAIL
					community during their annua CQR to ensure they are the correct UL listing and attached the wall. V. Plan of Correction completion date.	I	
					Plan of Completion date is September 28th, 2023.		

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