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	12/01/2022

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: 12/01/22 Facility Number: 002574 Provider Number: 155677 AIM Number: 201224380 At this Emergency Preparedness survey, Bell Trace Health & Living Center was found 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 76. Quality Review completed on 12/05/22	E 0000	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.	
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: 12/01/22 Facility Number: 002574 Provider Number: 155677 AIM Number: 201224380 At this Life Safety Code survey, Bell Trace Health	K 0000	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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrew Keen	HFA	12/19/2022

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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	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. 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 76 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 12/05/22		Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0761 SS=E Bldg. 01	Based on record review, observation and interview, the facility failed to maintain annual testing of 1 of 1 rolling fire door in accordance of NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less	K 0761	**K 761** **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 roll up door in the kitchen had an annual inspection documented. The Maintenance Supervisor has closed the door and padlocked it	12/12/2022

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	than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect all occupants in the dining room. Findings include: Based on record review with the Maintenance Supervisor 12/01/22 from 9:58 a.m. to 12:42 p.m., the most recent annual rolling fire door inspection was performed on 06/10/2020. Based on interview at the time of record review, the Maintenance Supervisor confirmed that the last annual inspection on rolling fire door was performed on 06/10/2020. During a tour of the facility on 12/01/22 with the Maintenance Supervisor, one rolling fire door was observed in the wall the separates the kitchen and dining room. This finding was reviewed with the Maintenance Supervisor at the exit conference. 3.1-19(b)		so it will not be used any more or until an inspection occurs. See attached picture showing the door is locked in a closed position. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All kitchen staff 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 kitchen roll up door inspected. See attached TELS Task labeled "Kitchen Roll up Door Inspection". **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will ensure that the annual roll up door inspection occurs and has the proper documentation during their annual CQR.	

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			V. Plan of Correction completion date. Plan of Completion date is December 12, 2022.	