STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155481	A. BUILDING -- B. WING	12/20/2017

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

(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 State Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/20/17 Facility Number: 000455 Provider Number: 155481 AIM Number: 100291010 At this Emergency Preparedness survey, Arbor Trace Health & Living Community was found in not compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 101 and had a census of 99 at the time of this survey. Quality Review completed on 12/27/17 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	**Arbor Trace requests paper compliance for the following deficiencies. This plan of correction is to serve as Arbor Trace's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.**	
E 0015 SS=C Bldg. --				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director and Administrator on 12/20/17 at 10:40 a.m., the facility's Emergency Preparedness plan provided did not address the loss of heating, cooling, and sewage and waste disposal in an emergency. Based on interview at the time of records review, the Administrator agreed the plan did not address the loss of sewage and waste disposal in an emergency.	E 0015	I. We updated our policies and procedures to include what we would do if we lost our ability to dispose of sewage and waste. II.The facility currently has no other policies and procedures not meeting guidelines for regulation E15. III.The systemic change includes updating policies and procedures if any changes are made to regulatory requirements concerning E15. IV.The Administrator (or designee) will discuss any changes made to regulatory requirements concerning E15 in our monthly quality assurance meetings. Our policies and procedures will subsequently be updated as changes arise.	01/12/2018

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E 0035 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director and Administrator on 12/20/17 at 11:10 a.m., the facility's Emergency Preparedness communication plan provided did not include a method for sharing information with residents and their families or representatives. Based on interview at the time of records review, the Maintenance Director and Administrator agreed the plan did not address a method for sharing information with residents and their families or representatives.	E 0035	I. We updated our policies and procedures to include a method for sharing information with residents and their families or representatives. II.The facility currently has no other policies and procedures not meeting guidelines for regulation E35. III.The systemic change includes updating policies and procedures if any changes are made to regulatory requirements concerning E35. IV.The Administrator (or designee) will discuss any changes made to regulatory requirements concerning E35 in our monthly quality assurance meetings. Our policies and procedures will subsequently be updated as changes arise.	01/12/2018
E 0036 SS=F Bldg. --	Based on record review and interview, the	E 0036	I. We updated our policies and procedures to include an	01/12/2018

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	facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director and Administrator on 12/20/17 at 10:55 a.m., the facility's Emergency Preparedness plan provided did not contain an emergency preparedness training and testing program. Based on interview at the time of records review, the Maintenance Director and Administrator agreed the plan did not contain an emergency preparedness training and testing program.		emergency preparedness training and testing program. II.The facility currently has no other policies and procedures not meeting guidelines for regulation E36. III.The systemic change includes updating policies and procedures if any changes are made to regulatory requirements concerning E36. IV.The Administrator (or designee) will discuss any changes made to regulatory requirements concerning E36 in our monthly quality assurance meetings. Our policies and procedures will subsequently be updated as changes arise.	
E 0037 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff,	E 0037	I. We updated our policies and procedures to include an emergency preparedness training and testing program. The annual training for ALL staff will take place 1/8/2018 and 1/11/2018 and annually thereafter. New hires will also complete initial training concerning our emergency	01/12/2018

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	individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all occupants. Findings Include: Based on record review with the Maintenance Director and Administrator on 12/20/17 at 11:35 a.m., the facility did not provide initial or annual emergency preparedness training for staff. Based on interview at the time of records review, the Administrator stated initial or annual training has not been conducted.		preparedness plan. This will start 1/10/2018 and will continue with all new hires. II. The facility currently has no other policies and procedures not meeting guidelines for regulation E37. III. The systemic change includes updating policies and procedures if any changes are made to regulatory requirements concerning E37. We will add emergency preparedness training and testing to our annual in-service calendar as a reminder for its completion. The emergency preparedness training and testing information will be added to our new hire training packets. IV.The Administrator (or designee) will discuss any changes made to regulatory requirements concerning E37 in our monthly quality assurance meetings. Our policies and procedures will subsequently be updated as changes arise. Any training needs concerning emergency preparedness will also be discussed in monthly QA meeting.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).	K 0000	**Arbor Trace requests paper compliance for the following deficiencies. This plan of correction is to serve as Arbor Trace's credible allegation of**	

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	Survey Date: 12/20/17 Facility Number: 000455 Provider Number: 155481 AIM Number: 100291010 At this Life Safety Code survey, Arbor Trace Health & Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident rooms. The healthcare portion of the facility has a capacity of 101 and had a census of 99 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.		**compliance.** **Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.**	

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	Quality Review completed on 12/27/17 - DA			
K 0355 SS=B Bldg. 02	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to maintain 1 of 1 K Class portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. NFPA 10, 5.5.5 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 5.5.5.3 requires a placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be actuated prior to using the fire extinguisher. This deficient practice could affect all patients, visitors, and staff using the main dining room. Findings include: Based on observations during a tour of the	K 0355	I. We purchased a placard from Koorsens identifying our kitchen's portable K Class fire extinguisher. II. That is the only portable K Class fire extinguisher. III. Compliance of this code will be ensured during preventative maintenance checks identifying possible issues. A work order will be generated if an issue is found and the problem will be resolved. IV. This safety code will be revisited once each month for 3 months, then once every 3 months for a total of 12 months of monitoring. The results of the reports and monitoring will be discussed at the monthly Quality Assurance Committee meeting.	01/12/2018

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	facility with the Maintenance Director on 12/20/17 at 12:33 p.m., the kitchen K Class fire extinguisher lacked a placard. Based on an interview at the time of observation, the Maintenance Director confirmed the kitchen K Class fire extinguisher lacked a placard identifying its use as secondary backup to the kitchen automatic fire suppression system. 3.1-19(b)			
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated			

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	protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 3 kitchen doors latched into the frame. This deficient practice could affect 50 residents that use the main dining room and staff in the kitchen. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 12/20/17 at 12:15 p.m. the right hand kitchen door from the dining room which was open to the corridor had a magnet over the strike plate preventing the door from latching. Based on interview at the time of observation, the Maintenance Director removed the magnet. 3.1-19(b)	K 0363	I. We removed the magnet and a door closure system is being purchased so the door can stay open while dietary is serving meals. The door will be closed once meal service and clean up is complete. II. No other doors in the kitchen were found to be affected by this deficient practice. III. Compliance of this code will be ensured during preventative maintenance checks identifying possible issues. Any issues will be reported to our dietary manager. The door closure system that will be placed on the door should prevent this deficient practice from occurring. IV. This safety code will be revisited once each month for 3 months, then once every 3 months for a total of 12 months of monitoring. The results of the	01/12/2018

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			reports and monitoring will be discussed at the monthly Quality Assurance Committee meeting.	
K 0524 SS=F Bldg. 02	NFPA 101 HVAC - Direct-Vent Gas Fireplaces Direct-Vent Gas Fireplaces Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54 1. Based on observation and interview; the facility failed to ensure 2 of 2 direct-vent fireplace were protected with carbon monoxide detection. LSC 19.5.2.3 (2) (f) states electrically supervised carbon monoxide detection in accordance with Section 9.8 shall be provided in the room where the fireplace is located. This deficient practice could affect all residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 12/20/17 at 11:13 a.m. and at 12:04 p.m., in the Fireside Lounge and the Parlor lounge there was a direct-vent fire place with no carbon monoxide detection. The lounges did have a detector but it was for smoke detection only. Based on interview at the time of observation, the Maintenance Director stated both lounges were not	K 0524	I. Simplex Grinnell has been called to install two carbon monoxide detectors. One will be placed in the fireside lounge and the other in the parlor lounge. We are going to purchase a covering that will prevent anyone from coming into contact with the sealed glass front of each fireplace. II. Those are the only two direct-vent fireplaces in our building. III. Compliance of this code will be ensured during preventative maintenance checks identifying possible issues. A work order will be generated if an issue is found and the problem will be resolved. IV. This safety code will be revisited once each month for 3 months, then once every 3 months for a total of 12 months of monitoring. The results of the reports and monitoring will be discussed at the monthly Quality Assurance Committee meeting.	01/12/2018

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	equipped with a carbon monoxide detection and the detector in the lounges was for smoke detection only. 3.1-19(b) 2. Based on observation and interview; the facility failed to ensure 2 of 2 direct-vent fireplace were protected with a wire mesh panel or screen. LSC 19.5.2.3 (2) (d) states the direct-vent fireplace shall include a sealed glass front with a wire mesh panel or screen. This deficient practice could affect all residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 12/20/17 at 11:13 a.m. and at 12:04 p.m., in the Fire side Lounge the Parlor lounge there was a direct-vent fire place with no mesh screen covering the sealed glass front. Based on interview at the time of observation, the Maintenance Director acknowledged the fire place did not have a mesh screen covering the sealed glass front. 3.1-19(b)			

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K 0741 SS=F Bldg. 02	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to enforce 1 of 1 smoking policies. This deficient practice could affect all residents that use the main health care entrance and employees that use the service and kitchen exit.	K 0741	I. The policy has been changed to reflect the current practice of employees and visitors being allowed to smoke in their car. There is a cigarette disposal container in the back parking lot by the garage. They may also smoke beside the container if they	01/12/2018

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	Findings include: Based on observation during a tour of the facility with Maintenance Director on 12/20/17 between 9:00 a.m. and 12:40 p.m., smoking was apparent on the non-smoking campus due to the following areas had cigarette butts on the ground: a) Outside the kitchen exit there were over 20 cigarette butts on the ground around the exit. b) Outside the service hall exit there were over 15 cigarette butts on the ground in the mulch. c) Outside the main health care exit there were over 30 cigarette butts on the ground in the mulch. d) Outside the main health care exit under the awning, there was a planter with 8 cigarette butts extinguished in the dirt. Based on records review with the Maintenance Director at 9:55 a.m., the smoking regulations stated all of the facility's property was smoke free. Based on interview at the time of observation and records review, the Maintenance Director agreed there were cigarette butts on the ground in the aforementioned areas and stated the facility is a smoke free campus. 3.1-19(b)		don't have a vehicle. II. The areas identified in the findings will have no smoking signs placed there so they are visible to employees and visitors. Two other areas were identified with butts on the ground and will have signs placed there so they are visible to employees and visitors. III. Compliance of this code will be ensured during preventative maintenance checks identifying possible issues. IV. This safety code will be revisited once each month for 3 months, then once every 3 months for a total of 12 months of monitoring. The results of the reports and monitoring will be discussed at the monthly Quality Assurance Committee meeting.	

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