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	02/20/2019

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: 02/20/19 Facility Number: 000455 Provider Number: 155481 AIM Number: 100291010 At this Emergency Preparedness survey, Arbor Trace Health & Living Community was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 101 certified beds. At the time of the survey, the census was 100. Quality Review completed on 02/25/19	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 0039 SS=F Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a	E 0039	1. There were no residents affected by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. 3. The facility will conduct an exercise to test the emergency plan using the emergency procedures. The systemic change includes the Administrator will schedule a full scale	03/22/2019

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

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	community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all residents in the facility. Findings include: Based on record review on 02/20/19 at 11:40 p.m. with the Maintenance Supervisor the facility did not a.) participate in a a. full scale community based exercise or b.) an individual facility based exercise for the past year. Nor had the facility experienced an actual natural or man made emergency which required the activation of the EPP. Based on interview with the Administrator during the exit conference it was acknowledged items a and b had not been done.		community based exercise and an individual facility based exercise have been completed at least annually. 4. The administrator will audit annually to determine a full scale community based exercise and an individual facility based exercise at lease annually. Results of the audit will be reported to the QA committee monthly to assist with additional recommendations if necessary.	
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 483.90(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: 02/20/19 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 483.90(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 fully sprinklered. 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 100 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinkled except for one garage which was not sprinklered. Quality Review completed on 02/25/19		**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.**	
K 0211 SS=E Bldg. 02	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2			

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	through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 8 exit discharges were continuously maintained free of obstructions. This deficient practice could affect 16 residents, visitors and staff on 100 Private hall. Findings include: Based on observation on 02/20/19 at 1:24 p.m. with the Maintenance Supervisor the 200 Short hall exit corridor stored an oxygen concentrator and two utility carts. This would be the secondary means of evacuation for residents on 100 Private hall. Based on interview at the time of the observation with the Maintenance Supervisor, it was acknowledged the 200 Short hall corridor exit was not maintained free of all obstructions. 3.1-19(b)	K 0211	1. There were no residents affected by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. The 2 utility carts and the oxygen concentrators have been removed from the 200 hall exit door. 3. Education will be provided to all staff regarding maintaining the exit doors free from obstruction. The systemic change will include daily rounds on the exit doors to keep them free from obstructions. 4. The Administrator/Designee will audit all exit doors to determine they are free from obstructions. Any identified issues will be corrected immediately. This audit will occur daily five times per week for 4 weeks then monthly to total 12 months of monitoring. Results of the audit will be reported to the QA committee monthly to assist with additional recommendations if necessary.	03/22/2019
K 0232 SS=E Bldg. 02	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5.			

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	19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet the clear width requirement for 1 of 5 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 16 residents, visitors and staff on 100 Private hall. Findings include: Based on observation on 02/14/19 at 1:26 p.m.	K 0232	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. The benches in the Main Street corridor have been removed. 3. Education will be provided to all staff regarding maintaining the corridors with the clear width requirement. The systemic change will include daily rounds on the corridors to keep the clear width maintained. 4. The Administrator/Designee will audit all corridors to determine the clear width is maintained. Any identified issues will be corrected immediately. This audit will occur daily five times per week for 4 weeks then monthly to total 12 months of monitoring. Results of the audit will be reported to the QA committee monthly to assist with additional recommendations if necessary.	03/22/2019

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	with the Maintenance Supervisor (MS) the Main street corridor measured eight feet wide and contained two, four foot bench which were not secured to the floor or wall and limited the corridor width to less than six feet. Based on interview at the time of the observation and measurement with the MS it was stated the benches could be moved. 3.1-19(b)			
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or			

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	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 1 staff service corridor door would close completely and latch into the door frame. This deficient practice could affect mostly staff and visitors on 300 hall LTC. Findings include: Based on observation on 02/20/19 at 12:37 p.m. with the Maintenance Supervisor (MS) the following corridor door leading into the staff service hall did not latch into its frame. Based on interview concurrent with the observation with the MS it was agreed the staff corridor door would not latch into its door frame. 3.1-19(b)	K 0363	1. There were no residents affected by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. The staff service corridor door is closing completely and latches into the door frame. 3. Education will be provided to all staff that any corridor door will close completely and latch into the door frame. The systemic change includes staff will notify the Administrator if a door does not close completely or latch into the door frame on a corridor. 4. The Administrator/Designee will audit all corridors doors to determine the door closes completely and latches into the door frame. Any identified issues will be corrected immediately. This audit will occur daily five times per week for 4 weeks then monthly to total 12 months of monitoring. Results of the audit will be reported to the QA committee	03/22/2019

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			monthly to assist with additional recommendations if necessary.	
K 0372 SS=E Bldg. 02	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 5 smoke barriers observed had a minimum of a 1/2 hour fire resistive rating and the penetrations caused by the passage of wire and/or conduit the smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect 8 residents, visitors and staff on Rosewood hall. Findings include: Based on observation on 02/20/19 at 2:12 p.m. with the Maintenance Supervisor (MS), above the ceiling access panel for the 200 hall smoke barrier wall next to Speech therapy had a one inch	K 0372	1. There were no residents affected by the alleged deficient practice. 2. All residents have to potential to be affected by the alleged deficient practice. The 200 hall smoke barrier wall was firestopped by staff during the tour. 3. Education will be provided to all staff related to the smoke barrier walls. All smoke barrier walls will be inspected to determine there are no breeches in the walls. Any identified issues will be corrected immediately. The systemic change includes if there is maintenance work done on the smoke barrier walls, maintenance will verify no breech has occurred	03/22/2019

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	opening into which several cables pentrated the smoke barrier and the opening was not firestopped. Based on interview with the MS it was confirmed the observation was valid and hole was firestopped by staff during the tour. 3.1-19(b)		to the smoke barrier wall and correct any identified issues immediately. 4. The administrator/designee will audit all smoke barrier walls for breeches. Any identified issues will be corrected immediately. This audit will occur daily five times per week for 4 weeks then monthly to total 12 months of monitoring. Results of the audit will be reported to the QA committee monthly to assist with additional recommendations if necessary.	
K 0911 SS=E Bldg. 02	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 1 electrical rooms on 300 hall. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). Distances shall be measured from the live parts if such parts	K 0911	1. There were no residents affected by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. The garbage can, compressor, chair and refrigerator have been removed from in front of the electrical panels in the Maintenance Office. 3. Education has been provided to the maintenance department regarding keeping the electrical panels free from items being	03/22/2019

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	are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect only staff in the electrical room. Findings include: Based on observation on 02/20/19 at 1:06 p.m. with the Maintenance Supervisor (MS), there was one garbage can, compressor, chair and refrigerator stored in front of several large electrical panels in the Maintenance office on 300 hall. Based on interview at the time of the observation, the MS acknowledged the aforementioned items should not be stored next the electrical panels. 3.1-19(b)		stored in front of them. The systemic change includes utilizing the garage to store items. 4. The administrator/designee will audit the maintenance office for items stored in front of the electrical panels Any identified issues will be corrected immediately. This audit will occur daily five times per week for 4 weeks then monthly to total 12 months of monitoring. Results of the audit will be reported to the QA committee monthly to assist with additional recommendations if necessary.	
K 0920 SS=E Bldg. 02	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet			

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	other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure proper use of surge protectors and extension cords in 4 of 4 areas observed. This deficient practice could affect 3 resident in rooms as well as visitors and staff. Findings include: Based on observations on 02/20/19 during the tour between 12:03 p.m. to 2:00 p.m. with the Maintenance Supervisor (MS), the following areas misused electrical surge protectors or extension cords: a. There was a surge protector within 6 feet of a patient Care Area (PCA) in resident room 414. b. There was an extension cord used to power a television set in resident room 421. c. There was a surge protector within 6 feet of a patient Care Area (PCA) in resident room 407. d. There was a surge protector connected to a surge protector in the communications room on 300 hall. Based on interview concurrent with the observations with the MS the misuse of surge protectors observed in items a-d was confirmed . 3.1-19(b)	K 0920	1. There were no resident affected by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. All resident rooms have been audited to determine no extension cords are used and all surge protectors meet UL 1363 requirements. Any issues identified have been corrected. 3. Education will be provided to all staff that electrical cords cannot be used in resident rooms and that all surge protectors must meet UL 1363 requirements. The systemic change includes the staff will report to the Administrator/maintenance department if there is an extension cord in use or a surge protector that does not meet UL 1363 requirements. 4. The administrator/designee will audit resident rooms for extension cords or surge protectors that do not meet UL 1363 requirements. Any identified issues will be corrected immediately. This audit will occur	03/22/2019

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			daily five times per week for five random rooms for 4 weeks then monthly to total 12 months of monitoring. Results of the audit will be reported to the QA committee monthly to assist with additional recommendations if necessary.	