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	10/01/2024

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/01/24 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 83. Quality Review completed on 10/02/24	E 0000		
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: 10/01/24 Facility Number: 002574 Provider Number: 155677 AIM Number: 201224380 At this Life Safety Code survey, Bell Trace Health	K 0000	October 17, 2024 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelsey Haislip	HFA	10/17/2024

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 83 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 10/02/24		Event ID: 031P21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on October 1, 2024. This letter is to inform you that the plan of correction attached is to serve as Bell Trace Health & Living Community credible allegation of compliance. We allege substantial compliance on October 17th, 2024. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 812-323-2858 Sincerely, Kelsey Haislip, HFA Administrator Bell Trace Health and Living Submission of this plan of correction in no way constitutes an admission by Bell Trace Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law.	

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			This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person	K 0324	**K 324** **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 commercial kitchen hood was cleaned every 6 months. The only cleaning documentation was from 4/25/2024. The Maintenance Supervisor had Whitlock clean the hood on 10/15/2024. See attached documentation from Whitlock. The Maintenance Supervisor double checked with Whitlock that their contract with them included cleaning every 6 months. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and associates could be affected by this deficient	10/15/2024

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	performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect staff in the kitchen. Findings include: Based on record review on 10/01/24 between 10:35 a.m. and 1:35 p.m. with the Maintenance Supervisor present, the only inspection documentation available during the past twelve months for the range hood exhaust system was dated 04/25/24. There was no range hood exhaust system inspection report available within six months prior to the 04/25/24 date. Based on interview at the time of record review, the Maintenance Supervisor said the range hood is due to be inspected and cleaned this month (October) and confirmed there was no range hood exhaust system inspection within six months prior to the 04/25/24 date available to review. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		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 current TELS task in the system to ensure the kitchen hood is being cleaned every 6 months. See attached TELS task labeled "BTHL Kitchen Hood Cleaning Task" **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect the kitchen hood cleaning and cleaning schedule during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is October 15th, 2024.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained with corresponding spare sprinklers on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 0353	**K 353** **I. The corrective actions to be accomplished for those residents found to have been**	10/15/2024

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	Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations during a tour of the facility with the Maintenance Supervisor and Administrator on 10/01/24 from 1:35 p.m. to 2:48 p.m., there was a sidewall sprinkler installed in the walk in freezer in the kitchen. Observation at the two sprinkler risers showed a spare sprinkler cabinet at each riser that held 12 spare pendant and upright sprinklers each. There were no spare sidewall sprinklers in either cabinet. Based on interview at the time of the observations, the Maintenance Supervisor confirmed a sidewall sprinkler is installed in the freezer and that there were no spare sidewall sprinklers on the facility premises at the time of the survey. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		**affected by the deficient practice.** Observation A- The Community failed to ensure that the spare sprinkler heads that were onsite included 2 sidewall sprinkler heads that matched the ones currently installed in the walk in Freezer. The Maintenance Supervisor has ordered 2 sprinkler heads from SafeCare. The Maintenance Supervisor has also added a separate spare sprinkler cabinet to house these heads. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and associates could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation A- There is a new semiannual TELS task created for the Maintenance Supervisor to inspect the spare sprinkler head storage cases to ensure that there are 2 sprinkler heads for each type installed within the community. See attached TELS task labeled "BTHL Spare Sprinkler Head	

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			Inspection Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect the spare sprinkler heads and storage cases during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is October 15th, 2024.	