STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155821	A. BUILDING -- B. WING	10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN TRACE HEALTH & LIVING COMMUNITY	3154 SOUTH STATE ROAD 135 GREENWOOD, IN 46143

(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: 10/13/22 Facility Number: 013185 Provider Number: 155821 AIM Number: 201221460 At this Emergency Preparedness survey, Aspen Trace Health and 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 104 certified beds. At the time of the survey, the census was 101. Quality Review completed on 10/17/22 The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:	E 0000	Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on Oct 13, 2022. This letter is to inform you that the plan of correction attached is to serve as Aspen Trace Health & Living Community credible allegation of compliance. We allege substantial compliance on October 28, 2022. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-535-3344 Sincerely, Emily Carnes Administrator Aspen Trace Health and Living	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Carnes		10/31/2022

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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	§483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in			

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	this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012.			

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	(x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review, observation and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Environmental Director from 9:15 a.m. to 12:10 p.m. on 10/13/22, thirty-six month period emergency generator testing documentation for four continuous hours for the diesel fired emergency generator was not available for review. Based on interview at the time of record review, the Environmental Director stated the facility has one diesel fired emergency generator and agreed documentation of supplemental load testing for four hours within the most recent three year period was not available for review. Based on observations with the Environmental Director and the Administrator in Training (AIT) during a tour of the facility from 12:40 p.m. to 3:10 p.m. on 10/13/22, the facility has one diesel fired emergency generator located outside the building. Manufacturer's nameplate rating for the generator stated it was rated at 250 kW. This finding was reviewed with the Environmental	E 0041	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The community failed to ensure that the diesel fired generator had a 4-hour load bank test on file. The Maintenance Supervisor has contacted Buckeye Power to do a 4-hour load bank test and they will be onsite Nov 14th to perform this test. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Resident and Staff in the community could be affected by this deficiency. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**	11/14/2022

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	Director during the exit conference.		There is a new TELS task to have a 4-hour load bank test conducted every 36 Months. See attached task labeled “Aspen Trace Generator Testing” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team will monitor the generator testing frequency and documentation during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is Nov 14th, 2022	
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: 10/13/22 Facility Number: 013185 Provider Number: 155821 AIM Number: 201221460 At this Life Safety Code survey, Aspen Trace Health and Living Community was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a),	K 0000	Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on Oct 13, 2022. This letter is to inform you that the plan of correction attached is to serve as Aspen Trace Health & Living Community credible allegation of compliance. We allege substantial compliance on October 28, 2022. We are requesting paper compliance for this plan of correction.	

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	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, in all areas open to the corridors with hard wired smoke detectors in all resident rooms. The facility has a capacity of 104 and had a census of 101 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 10/17/22		If you have any further questions, please do not hesitate to contact me at 317-535-3344 Sincerely, Emily Carnes Administrator Aspen Trace Health and Living	
K 0211 SS=E Bldg. 01	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 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to maintain the means of egress free from obstructions in 1 of 11 means of egress. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility by Room 612. Findings include: Based on observations with the Environmental	K 0211	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The Community failed to ensure that the west exit door near room 612 did not unlatch during inspection. The	10/30/2022

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	Director and the Administrator in Training (AIT) during a tour of the facility from 12:40 p.m. to 3:10 p.m. on 10/13/22, the west door in the exit door set to the outside of the facility by Room 612 was stuck on the threshold for the door set and would not release to open. Both doors in the exit door set were marked with the necessary signage for delayed egress doors. The east door in the door set released to open after pushing for 15 seconds. The west door did not release to open after pushing on the door for 15 seconds because the door was stuck on the threshold. The door set could also be opened by entering a code at the wall mounted keypad by the door set but the west door still would not release to open because it was stuck on the threshold. Based on interview at the time of the observations, the Environmental Director agreed the west door in the exit door set being stuck on the threshold did not maintain the aforementioned means of egress free from obstructions. This finding was reviewed with the Environmental Director and the AIT during the exit conference. 3.1-19(b)		Maintenance Supervisor has contracted with Your Automatic Door to make these repairs. See attached estimate for these repairs and that the parts are on order. This is a double door to the outside and 1 side of the door unlatches properly. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Resident and Staff on the 600 Hall could be affected by this deficiency. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There was an existing TELS Task to inspect all emergency egress doors monthly. (See attached Task labeled “Aspen Egress Door Inspection”) **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team will monitor and inspect all corridor doors during their annual CQR.	

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K 0761 SS=F Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the	K 0761	**V. Plan of Correction completion date.** Plan of Completion date is October 30, 2022 **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The Community failed to ensure that the annual fire door inspection included all the fire rated doors. Glenn Smith with CarDon Corporate has re inspected the community and included all the fire rated doors in his inspection. See attached documentation from this inspection. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and Staff could be affected by this deficiency. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**	10/30/2022

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	following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Annual Fire/Smoke/Egress Door Inspection" documentation dated 01/27/22 with the Environmental Director during record review from 9:15 a.m. to 12:10 p.m. on 10/13/22, annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period did not include all fire doors in the facility. A floor plan map which identified		There was an existing TELS Task to inspect all fire rated doors annually. See attached TELS task labeled “Aspen Annual Fire Door Testing” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team will monitor and inspect all corridor doors during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is October 30, 2022	

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	which fire door locations were inspected was included with the 01/27/22 inspection documentation. The 01/27/22 inspection documentation did not include hazardous areas in the facility which were constructed prior to 2016. Based on observations with the Environmental Director and the Administrator in Training (AIT) during a tour of the facility from 12:40 p.m. to 3:10 p.m. on 10/13/22, entry room doors to over 10 hazardous areas such as fuel fired heater rooms, laundries larger than 100 square feet, soiled linen and trash collection rooms, physical plant maintenance shops and storage rooms larger than 100 square feet used for storing combustible material were noted in the facility. Each entry door to the rooms was a fire-rated door with a minimum 1-hour fire resistance rating. In addition, two 90-minute fire resistance rated doors were noted in the tenant separation wall of the activity room by the first floor of the Assisted Living area on the east side of the building. The two 90-minute fire resistance rated doors were not included on the 01/27/22 inspection documentation. Based on interview at the time of the observations, the Environmental Director agreed it could not be ensured all fire door locations in the facility were included in the 01/27/22 inspection documentation. This finding was reviewed with the Environmental Director and the AIT during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable			

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	of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review, observation and interview; the facility failed to document 36 month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10,	K 0918	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The community failed to ensure that the diesel	11/14/2022

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ASPEN TRACE HEALTH & LIVING COMMUNITY	3154 SOUTH STATE ROAD 135 GREENWOOD, IN 46143

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	Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Environmental Director from 9:15 a.m. to 12:10 p.m. on 10/13/22, thirty-six month period emergency generator testing documentation for four continuous hours for the diesel fired emergency generator was not available for review. Based on interview at the time of record review, the Environmental Director stated the facility has one diesel fired emergency generator and agreed documentation of supplemental load testing for four hours within the most recent three year period was not available for review. Based on observations with the Environmental Director and the Administrator in Training (AIT) during a tour of the facility from 12:40 p.m. to 3:10 p.m. on 10/13/22, the facility has one diesel fired emergency generator located outside the building. Manufacturer's nameplate rating for the generator stated it was rated at 250 kW. This finding was reviewed with the Environmental		fired generator had a 4-hour load bank test on file. The Maintenance Supervisor has contacted Buckeye Power to do a 4-hour load bank test and they will be onsite Nov 14th to perform this test. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Resident and Staff in the community could be affected by this deficiency. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a new TELS task to have a 4-hour load bank test conducted every 36 Months. See attached task labeled “Aspen Trace Generator Testing” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team will monitor the generator testing frequency and documentation during their annual CQR.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155821	A. BUILDING 01 B. WING	10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Director during the exit conference. 3.1-19(b)		**V. Plan of Correction completion date.** Plan of Completion date is Nov 14th, 2022	