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	11/30/2022

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

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E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 10/13/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/30/22 Facility Number: 013185 Provider Number: 155821 AIM Number: 201221460 At this PSR survey to the Emergency Preparedness survey, Aspen Trace Health and Living Community was found 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 91. Quality Review completed on 11/30/22	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 10/13/11 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/30/22 Facility Number: 013185 Provider Number: 155821 AIM Number: 201221460	K 0000		

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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	At this PSR survey, Aspen Trace Health and Living Community was found not in compliance with Requirements for Participation 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, 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 91 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 11/30/22			
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 with 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,	K 0761	**K761** **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	12/05/2022

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	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 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 fully 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		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.** 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	

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	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 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		December 5, 2022	

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	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. Based on review of the edited "Annual Fire/Smoke/Egress Door Inspection" documentation still dated 01/27/22 with the Environmental Director during record review from 9:10 a.m. to 9:40 a.m. on 11/30/22, annual inspection documentation of fire door assemblies in the facility within the most recent twelve-month period still did not include all fire doors in the facility. A floor plan map which identified which fire door locations were inspected was included with the edited 01/27/22 inspection documentation. Fire door locations 'S' and 'T' were added as inspected and tested on 10/24/22 on the edited but still dated 01/27/22 inspection documentation. Based on interview at the time of record review, the Environmental Director stated fire door location 'S' was for one fire door location for a natural gas fired heater room and fire door location 'T' was a door in the first-floor separation wall for Assisted Living. Based on interview at the time of record review, the Environmental Director stated no additional hazardous area fire door locations were inspected or tested on or after 10/13/22 because these fire door locations were in areas behind fire doors already inspected on 01/27/22 such as the entrance to the service corridor. This finding was reviewed with the Environmental Director during the exit conference. This deficiency was cited on 10/13/22. The facility failed to implement a systemic plan of correction			

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	to prevent recurrence. 3.1-19(b)			