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	08/01/2023

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: 08/01/23 Facility Number: 013185 Provider Number: 155821 AIM Number: 201221460 At this 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 92. Quality Review completed on 08/07/23	E 0000	August 14, 2023 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on August 1, 2023. 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 August 8, 2023. 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,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Carnes		08/14/2023

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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			Emily Carnes Administrator Aspen Trace Health and Living Submission of this plan of correction in no way constitutes an admission by Aspen 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. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
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).	K 0000	August 14, 2023	

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	Survey Date: 08/01/23 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), 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 92 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 08/07/23		Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on August 1, 2023. 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 August 8, 2023. 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	

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			Submission of this plan of correction in no way constitutes an admission by Aspen 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. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in			

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	accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on record review, observation and interview; the facility failed to maintain the 2-hour fire rated separation between the skilled nursing unit and the attached assisted living area in accordance with Section 19.1.3.4.1. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the corridor door set by the Activities Room by the first floor entrance to Assisted Living. Findings include: Based on observations with the Environmental Director and the Maintenance Assistant during a tour of the facility from 12:30 p.m. to 2:55 p.m. on 08/01/23, each door in the corridor door set to Assisted Living on the first floor by the Activities Room was equipped with a 90-minute fire resistance rating label affixed to the hinge side of the door. A six inch in diameter open ended conduit passed through the tenant separation wall above the suspended ceiling above the aforementioned corridor door set and was not firestopped. The open ended conduit was for the passage of over 20 black cables through the wall. Review of facility blueprints found in the main fire alarm control panel room at 2:10 p.m. on 08/01/23 indicated the tenant separation wall at the corridor door set to Assisted Living on the first floor by	K 0131	**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 areas of penetration in firewall were properly sealed. Area of firewall penetration was sealed with firestop muffin by Maintenance Director. See attached picture showing the completed sealed penetration. **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**	08/08/2023

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	the Activities Room was constructed as a 2-hour fire resistance rated wall. Based interview at the time of record review and of the observations, the Environmental Director agreed the open ended conduit which passed through the tenant separation wall above the aforementioned corridor door set was not firestopped to maintain the 2-hour fire resistance rating of the tenant separation wall. These findings were reviewed with the Executive Director and the Environmental Director during the exit conference. 3.1-19(b)		**deficient practice does not recur.** There is a new TELS task to check fire wall penetration. See attached task labeled “Aspen Trace Fire Wall Penetration” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team will monitor and inspect fire walls for proper sealants during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is August 8, 2023.	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or			

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	* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 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 performing the work, and the date of inspection or cleaning shall be maintained on the premises.	K 0324	**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 the hood cleaning occurred within 6 months of the last cleaning in October 2023. The Maintenance Supervisor had the new vendor scheduled to clean the hood in July 2023. See attached documentation showing the last hood cleaning. **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.**	08/01/2023

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	This deficient practice could affect over two staff in the kitchen. Findings include: Based on review of the kitchen range hood inspection contractor's "Courtesy After Service Report" documentation dated 10/20/22 and "Job Service Report" documentation dated 07/18/23 with the Environmental Director during record review from 9:05 a.m. to 12:10 p.m. on 08/01/23, it was greater than six months in between the two most recent kitchen exhaust system inspections. Based on interview at the time of record review, the Environmental Director stated the facility changed kitchen range hood inspection contractors in between the two most recent kitchen range hood inspections and agreed it was greater than six months in between the two most recent kitchen exhaust system inspections. These findings were reviewed with the Executive Director and the Environmental Director during the exit conference. 3.1-19(b)		There is a new TELS task to have hood cleaned every 6 Months. See attached task labeled “Aspen Trace Hood Cleaning” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team will monitor the hood cleaning frequency and documentation during their annual CQR. **V. Plan of Correction completion date.**	
K 0761 SS=E 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	K 0761	**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	08/08/2023

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	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 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		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.** 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.**	

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	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 over 20 residents, staff and visitors in the vicinity of the Activities Room by the first floor entrance to Assisted Living. Findings include: Based on review of "Annual Fire/Smoke/Egress Door Inspection" documentation dated 01/19/23 with the Environmental Director during record review from 9:05 a.m. to 12:10 p.m. on 08/01/23, 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 01/19/23 inspection documentation. The 01/19/23 inspection documentation did not include the door to the storage closet in the tenant separation wall in the Activities Room. Based on observations with the Environmental Director and the Maintenance Assistant during a tour of the facility from 12:30 p.m. to 2:55 p.m. on 08/01/23, the entry door to the storage closet in the Activities Room in the tenant separation wall was equipped with a 90-minute fire resistance rating label affixed to the hinge side of the door. Review of facility blueprints found in the main fire alarm control panel room at 2:10 p.m. on 08/01/23 indicated the entry door to the storage closet in the Activities Room is in the tenant separation wall for Assisted Living. Based		Plan of Completion date is August 8, 2023.	

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	on interview at the time of record review and of the observations, the Environmental Director agreed it could not be ensured all fire door locations in the facility were included in the 01/19/23 inspection documentation. These findings were reviewed with the Executive Director and the Environmental Director during the exit conference. 3.1-19(b)			