

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
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NAME OF PROVIDER OR SUPPLIER CUMBERLAND TRACE HEALTH & LIVING COMMUNITY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1925 REEVES ROAD PLAINFIELD, IN 46168
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K 000 Bldg. 01	<p>An Initial Life Safety Code Certification and State Licensure Survey for a new facility with 104 certified Comprehensive beds was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/23/15</p> <p>Facility Number: 013455 Provider Number: 013455 AIM Number: NA</p> <p>At this Initial Life Safety Code and Environmental survey, the portion of Cumberland Trace Health & Living LLC which will be certified was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety From Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and with 410 IAC 16.2-3.1-19, Environment and Physical Standards of the Indiana Health Facilities Rules for Comprehensive Care Facilities.</p> <p>The portion of Cumberland Trace Health & Living which will be certified is a one</p>	K 000	<p>April 24, 2015</p> <p>Kim Rhoades, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204</p> <p>Re: Allegation of Compliance</p> <p>Dear Ms. Rhoades:</p> <p>Please find enclosed the Plan of Correction to the annual Life Safety Code Survey conducted on April 23, 2015. This letter is to inform you that the plan of correction attached is to serve as Cumberland Trace's credible allegation of compliance. We allege compliance on April 24, 2015. We are requesting a desk review for this plan of correction.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>story facility determined to be of Type V (111) construction and fully sprinklered. There is a two hour fire-rated separation from the two story residential area. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and in each resident room. The facility has a total capacity of 176 Licensed beds with 104 Comprehensive beds and 72 Residential beds and had a census of 0 at the time of this visit.</p>		<p>If you have any further questions, please do not hesitate to contact me at 317-838-7070.</p> <p>Sincerely,</p> <p>Tom Mullins, HFA</p> <p>Administrator</p>	

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K 017 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Corridor walls form a barrier to limit the		<p>Submission of this plan of correction in no way constitutes an admission by Cumberland 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 other services provided in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Cumberland Trace reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis of the deficiency. This plan of correction serves as the allegation of compliance by April 24, 2015.</p> <p>This statement of deficiencies and plan of correction will be reviewed at the next Quality Assurance/Assessment Committee meeting.</p>		

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	<p>transfer of smoke. Such walls are permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 open use areas were separated from the corridor or met an Exception. LSC 18.3.6.1, Exception # 1 Spaces shall be permitted to be unlimited in area and open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect at least 30 residents, staff and visitors in the facility.</p> <p>Findings include:</p>	K 017	<p>K17 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Automatic smoke detection systems were installed in all 4 personal laundry alcoves. II. The facility will identify other residents that may potentially be affected by the deficient practice. There were no residents residing at the facility at the time of the inspection. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. The Director of Maintenance was educated on the life safety requirement of automatic smoke detection systems in laundry areas. Maintenance Director or designee has observed remaining laundry area smoke detectors within facility. Any smoke detectors found out of compliance were corrected. IV The facility will monitor the corrective action by implementing the following measures. Results of the observations will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V.</p>	04/24/2015

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K 051 SS=F	<p>Based on observation with the Regional Facilities Manager and the Maintenance Director during a tour of the facility from 9:00 a.m. to 1:15 p.m. on 04/23/15, each of the four wings had a personal laundry alcove with a sliding pocket door. These alcoves were open to the corridor because the sliding pocket doors to the alcoves were not equipped with positive latching devices to latch the door into the door frame. Furthermore, Exception # 1, requirement (c) of the Life Safety Code, Chapter 18.3.6.1 was not met as follows: the personal laundry alcoves were not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurse's station. Based on interview at the time of the observations, the Regional Facilities Manager and the Maintenance Director acknowledged the personal laundry alcoves were open to the corridor and were not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurse's station.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		<p>Plan of Correction completion date. Plan of Completion date is April 24, 2015.</p>				

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Bldg. 01	<p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 5 of 5 manual fire alarm boxes within a vestibule were readily accessible. NFPA 72, The National Fire Alarm Code, 2-8.2.1 states manual fire alarm boxes shall be distributed throughout the protected area so that they are unobstructed, readily accessible, and located in the path of exit from the area. This deficient practice could affect at all residents, staff and visitors within the facility.</p> <p>Findings include:</p> <p>Based on observation with the Regional Facilities Manager and the Maintenance Director during a tour of the facility from 9:00 a.m. to 1:15 p.m. on 04/23/15, the</p>	K 051	<p>K 51 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. The manual fire alarm pull stations in the main entrance, 400 wing, 500 wing, 600 wing and 700 wing vestibules were relocated to readily accessible areas. II. The facility will identify other residents that may potentially be affected by the deficient practice. There were no residents residing at the facility at the time of the inspection. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. The Maintenance Director was educated on the life safety requirement of manual fire alarm pull stations being located in readily accessible areas.</p>	04/24/2015

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	<p>manual fire alarm pull stations in the main entrance, 400 wing , 500 wing, 600 wing and 700 wing vestibules were not readily accessible in that the pull stations were located beyond the magnetically locked exit door and would require pushing on the door and waiting 15 seconds or the use of a code to access the pull station. Based on interview at the time of observation, the Regional Facilities Manager and the Maintenance Director acknowledged a person would require pushing on the door and waiting 15 seconds or the use of a code to access the pull station.</p> <p>3.1-19(b)</p>		<p>Maintenance Director or designee has observed manual fire alarm pull stations within facility. Any manual fire alarm pull stations found out of compliance were corrected. IV The facility will monitor the corrective action by implementing the following measures. Results of the observations will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is April 24, 2015.</p>				