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| | 155836 | A. BUILDING 00<br>B. WING | 04/23/2024 |

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| CUMBERLAND TRACE HEALTH & LIVING COMMUNITY | 1925 REEVES ROAD<br>PLAINFIELD, IN 46168 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00427629. This visit included a State Residential Licensure Survey.<br><br>Complaint IN00427629 - No deficiencies related to the allegations are cited.<br><br>Survey dates: April 15, 16, 17, 18, 19, 22, and 23, 2024.<br><br>Facility number: 013455<br>Provider number: 155836<br>AIM number: 201293440<br><br>Census Bed Type:<br>SNF/NF: 70<br>SNF: 30<br>Residential: 61<br>Total: 161<br><br>Census Payor Type:<br>Medicare: 12<br>Medicaid: 44<br>Other: 44<br>Total:100<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on May 3, 2024. | F 0000 | | |
| F 0550<br>SS=G<br>Bldg. 00 | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights<br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>Based on observation, interview, and record review, the facility failed to ensure a resident | F 0550 | The plan of correction is to serve as Cumberland Trace's credible | 05/20/2024 |

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| | (Resident 83) was treated with respect and dignity for 1 of 6 residents who attended and complained during an Indiana Health Department (IDOH) Resident Council meeting. This deficient practice resulted in psychosocial harm when the facility failed to provide interventions for her ongoing roommate concerns causing Resident 83 to be afraid to continue complaining about the situation, she began to lose sleep, had bad dreams, isolated herself in her room, became more tearful, and required an increase in her medication. (Residents 83 and 30).<br><br>Findings include:<br><br>On 4/15/24 at 11:28 a.m., Resident 83 was observed. She appeared to be asleep in her recliner. Her eyes were closed, and she had calm, regular respirations. She did not wake to the sound of a knock on her door.<br><br>On 4/18/24 at 1:00 p.m., Resident 83's roommate, Resident 30, could be heard from several rooms down the hall as she yelled out "Ow! Ow! Ow!" Qualified Medication Aide (QMA) 49 approached the room to assist the resident and indicated the resident always yelled out like that.<br><br>On 4/19/24 at 1:30 p.m., an IDOH Resident Council Meeting was conducted with the following residents present: Residents 83, 5, 14, 44, 56, and 62. The following concerns were voiced by Resident 83 and the other residents on her behalf: Resident 83 received a new roommate, Resident 30, several months ago. Resident 83 indicated at first things were okay, but soon her roommate started yelling out for help a lot of time throughout the night and Resident 83 couldn't sleep. After a while Resident 30's yelling out and screaming got worse so that other residents next | | allegation of compliance.<br><br>Submission of this plan of correction does not constitute an admission by Cumberland Trace and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.<br><br>F 550 Resident Rights/Exercise of Rights<br>I The corrective actions to be accomplished for those residents found to be affected by the alleged deficient practice.<br>Respect and dignity are being maintained for the affected resident by providing psychosocial and medical care when concerns are voiced or when s/s of anxiety or depression are noted.<br><br>II The facility will identify other residents that may potentially by affected by the practice.<br><br>Dignity and respect are being maintained for all other residents by identifying when psychosocial distress is observed, and interventions are being | |

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| | door and across the hall began to hear it and become frustrated. One resident indicated, "I live close enough to hear her yell all the time, but I can close my door, I don't know how Resident 83 has dealt with it this long." During the conversation, Resident 83 became tearful, her voice waivered and her hands shook as she indicated she was afraid to keep complaining about the roommate because she didn't want to get either of them in trouble. She indicated she was a very sensitive person and since she was not sleeping well anymore she felt more irritable and snapped at the staff and her peers. Because she wasn't sleeping very well she was waking up from disorienting dreams that made her confused and scared. She also felt weaker throughout the days because she was so tired. Resident 83 and the other residents all indicated they knew staff were aware of the problem because they could hear the roommate scream all the time and had to be the ones to take care of her, and staff had provided ear plugs for those that had rooms close to Resident 30.<br><br>On 4/19/24, upon the completion of the Resident Council Meeting, Resident 83 was privately interviewed and became tearful, her voice was shaking when talked about her roommate always yelling out for help. Resident 83 stated she did not get any rest unless she slept when the roommate was not in the room. She had been isolating herself from the dining room and activities in order to sleep. She felt she must tend to her roommate's outbursts to try to calm her down because the noise was making other residents angry. Resident 83 did not want other residents upset with her because of Resident 30. Resident 83 stated no matter what anyone did for Resident 30 she was always yelling, even when she was out of the room, but no one did anything about it. Resident 83 stated the lack of sleep was causing her to | | implemented.<br><br>III The facility will put into place the following systematic changes to ensure that the practice will not recur.<br>Staff are being educated on signs and symptoms of psychosocial distress and who to report those observations to.<br><br>IV The facility will monitor the corrective action by implementing the following measures.<br><br>The Administrator or Designee will do random interviews with residents of the facility to ensure residents are experiencing an environment that promotes quality of life, and the residents are not experiencing psychosocial distress. Weekly x 4 weeks, then monthly for 2 months then quarterly for 3 quarters.<br><br>The results of these audits will be discussed at the facility Quality Assurance meetings monthly times 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.<br><br>V Plan of Correction completion date. | |

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| | have bad dreams that were scaring her. She did not feel rested. She was reluctant to have anyone advocate on her behalf for fear of retaliation by both staff and other residents.<br><br>During an interview on 4/19/24 at 2:45 p.m., Certified Nursing Adie (CNA) 27 indicated Resident 83 had stayed in her room a lot more recently. Resident 83 had a roommate, Resident 30, who screamed and yelled out a lot of the times and it kept Resident 83 awake at night. Resident 83 had been sleeping through breakfast and lunch a lot more, and sometimes skipped activities she liked in order to go take a nap when Resident 30 was not in the room.<br><br>During an interview on 4/19/24 at 2:50 p.m., QMA 49 indicated, Resident 83's biggest issue was her roommate, Resident 30. Before Resident 30 moved in, Resident 83 was a happy person and liked to get up in time for breakfast in the dining room with her friends, but now she had a personality change. She did not get up on time and sometimes when staff tried to wake her up she would yell or be mean to them, but then she would come out and apologize and say that it was because she did not feel good since she did not sleep well.<br><br>During an interview on 4/19/24 at 3:00 p.m., the Director of Nursing of Record (DON of Record) and Unit Manager 164 indicated Resident 83's biggest issue that they knew of was related to her roommate yelling and screaming out which kept her awake at night. When asked how long this had been happening, UM 164 indicated since at least March 2024. The DON of Record indicated Resident 30 had Lewy Body dementia which did cause some behavioral disturbances. The DON of Record indicated Resident 83 had a very sensitive, modest, and reserved personality so she could | | Date of Compliance: 5/20/24<br>The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.<br><br>IDR - Due to we do not believe actual harm occurred. | |

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| | understand why the screaming and yelling out would bother her.<br><br>On 4/22/24 at 9:20 a.m., Resident 83 and 30's medical records were reviewed in tandem to determine if Resident 30's behavior correlated with Resident 83's decline in sleep and psychosocial health. Documentation in a day to day chronological order from both Resident 83 and Resident 30 indicated the following:<br><br>On 4/22/24 at 9:20 a.m., Resident 83's record was reviewed. Resident 83 had diagnoses which included, but were not limited to, mild cognitive impairment, encephalopathy (a group of conditions that cause brain dysfunction), attention and concentration deficit, major depressive disorder, and a new diagnosis of insomnia (trouble falling or staying asleep) was added on 1/4/24.<br><br>Resident 83's record had documentation that indicated she was seen on a regular basis by a Geri-psychiatric and a counseling provider. Sessions before she received her new roommate included but were not limited to the following:<br><br>A counseling provider progress note, dated 11/14/23, indicated Resident 83 was able to reflect that she was "proud of herself" as after she rested and "did not hold a grudge" as she used prior coping skills and self-soothing statements, and it was noted that she was beginning to change some of her behavior and behavior patterns which positively impact her depression.<br><br>A counseling provider progress note, dated 11/28/23, indicated Resident 83 explored the ways that low self-esteem affects current relationships and helped her accept that healthy relationships | | | |

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| | improve mood. She explored her pattern of being a highly sensitive person to environmental stimulus and gaining insight into her pattern of absorbing environmental energy (empath) and coping skills were discussed to reduce their impact.<br><br>A counseling provider progress note dated 12/12/23 indicated, Resident 83 worked to schedule a healthy and effective daily routine that will decrease depression, whilst giving her space to decline attending activities she did not want to go to and role-played assertive communication to communicate with others.<br><br>On 4/22/24 at 9:20 a.m., the record for Resident 30 (the roommate) was reviewed. Resident 30 had diagnoses which included, but were not limited to, unspecified dementia, anxiety and dissociative and conversation disorder. Resident 30 completed a rehabilitation stay and moved into Resident 83's room on 12/27/23.<br><br>Resident 30's (the roommate) record included an Intra-Facility Transfer Notice, dated 12/27/23, indicated Resident 30's responsible party was notified and waived the 2-day (48 hour) notice of room move. The reason for the transfer indicated, "Resident needed a semi-private MCD [Medicaid certified] bed.<br><br>A nursing progress note for Resident 30 (the roommate), dated 12/27/23 at 4:38 p.m., indicated Resident 30 was moved into her new room and introduced to "some residents."<br><br>A nursing progress note for Resident 30 (the roommate), dated 12/27/23 at 10:51 p.m., indicated, Resident 30 " ...states to this nurse that she can get very difficult ...." | | | |

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| | Resident 83's record lacked documentation that she was notified that she would receive a new roommate on, when she would receive the new roommate, and/or if they had the opportunity to "Meet and Great."<br><br>A progress note for Resident 83, dated 1/2/24 at 4:11 p.m., indicated the Social Services Director (SSD) visited with Resident 83. Resident 83 was in bed at that time. She was asleep at first, but the CNA delivered lunch and had to wake her up. Resident 83 voiced her concern about having the option of sleeping longer in the mornings. She was given the opportunity to express her thoughts and feelings and was receptive to suggestions and self-reported she "promised the aid she would get up for lunch." Resident talked about her understanding of staffs' concerns about her well-being and being up for breakfast.<br><br>A counseling provider progress note for Resident 83, dated 1/2/24, indicated Resident 83 reported she had " ...impaired sleep as her roommate yelled out multiple times in the night and she needed support to express her concerns. She felt better about being able to express her concern about her roommate and she is hopeful that things will improve and wants to give it time before saying anything ...." Resident 83 was dealing with minor stressors that could be problematic if not resolved and can self-advocate and has the skills to speak to staff of the situation with her roommate becomes too difficult for her. "Staff spoke to me before the session and were already aware of the situation."<br><br>A nursing progress note for Resident 30 (the roommate), dated 1/02/24 at 10:28 a.m., indicated Registered Nurse (RN) 157 and a CNA went to answer Resident 30's call light. Resident 30 | | | |

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| | complained at length, raised her voice, yelled and made allegations against the nursing staff.<br><br>A nursing progress note for Resident 30 (the roommate), dated 2/6/24 at 3:58 p.m., indicated " ...Approximately at 2:45 p.m., [Resident 30] was yelling for help. Resident stated that she need to use the bedpan. CNA took resident to her room and was going to assist her on the bedpan with help using the Hoyer. Once in the resident's room, she began yelling that she wanted to go back out to the TV room. Once again, resident started yelling while in the comm area and stating no one would help her and again CNA took resident back to her room with 2nd CNA to place her in bed and on the bedpan. After peri-care CNAs put resident back in her chair and brought her out to the common area. Once again resident started yelling and this writer called her son Chris r/t [related to] to her behaviors that started at breakfast and were escalating ...."<br><br>A nursing progress note for Resident 30 (the roommate), dated 2/7/24 at 12:18 a.m., indicated Resident 30 called out "ooohhhh" repeatedly ... assistance was offered but declined, but shortly after Resident 30 called out again.<br><br>A nursing progress note for Resident 30 (the roommate), dated 2/7/24 at 3:20 a.m., indicated Resident 30 was heard hollering out "ooohhh, help." Upon entering room, she requested CNAs to sit her up in her bed. Resident was assisted to a sitting position. Shortly after CNAs left the room, she began hollering out again.<br><br>A nursing progress note for Resident 30 (the roommate), dated 2/7/24 at 6:42 a.m., indicated the CNA reported to the nurse that Resident 30 was calling out for help. Upon entering room, CNA | | | |

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| | reported that Resident 30 was asked "what is going on? Is everything ok?" and "why are you yelling out, do you need help?" Resident 30 stated "I was hoping that somebody would pass and hear me."<br><br>A nursing progress note for Resident 30 (the roommate), dated 2/8/24 at 4:10 p.m., indicated the SSD visited with Resident 30. The resident "could not recall her yelling out episodes during the night or how she slept. Resident reluctant to talk."<br><br>A nursing progress note for Resident 30 (the roommate), dated 2/10/2024 at 12:00 a.m., indicated Resident 30 was yelling "help" early and became more agitated and argumentative. Attempts were made without success, to redirect the resident. The CNA and nurse repositioned resident and made sure that call light was within reach, then the resident stated she wanted to get up. Tried to redirect her "stating that it was midnight," and encouraged Resident 30 to get some rest. TV was on and was turned off and encouraged the resident to try to get some rest. Resident 30 could be heard complaining as staff walked away that no one was willing to help her. CNA and this writer in her room for 20 minutes.<br><br>A psychiatric provider progress note for Resident 83, dated 2/19/24, indicated staff reported the patient had intermittent difficulty with depression. "They also confirmed she is having difficulty with sleep." The psychiatric provider reviewed her physician order for Melatonin 6 mg (milligrams) at bedtime and increased her dose to 9 mg. Further, the psychiatric provider reviewed her current dose of an antidepressant medication and indicated if symptoms did not improve they could increase her dose." | | | |

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| | A nursing progress note for Resident 30 (the roommate), dated 2/21/24 at 3:09 p.m., indicated Resident 30 requested to go to room after lunch, approximately 20 minutes later she was heard moaning and crying. She was repositioned.<br><br>A nursing progress note for Resident 30 (the roommate), dated 2/21/24 at 4:04 p.m., indicated the SSD visited Resident 30 for follow up as staff reported she had been yelling out and was tearful.<br><br>A nursing progress note for Resident 83, dated 2/21/24 at 8:29 a.m., Resident 83 was asleep and had to be woken up for a reminder that it was beauty shop day. She had to be re-woken a second time at 10:00 a.m., to get ready for the beauty shop.<br><br>A nursing progress note for Resident 83, dated 2/21/24 at 10:55 a.m., Resident 83 had not complained of any increased drowsiness related to her increase of melatonin.<br><br>A nursing progress note for Resident 83, dated 2/22/24 at 9:18 p.m., indicated Resident 83 had been "overheard complaining that she did not sleep well last night because the blonde haired nurse did not give her medications. This nurse worked the previous evening and resident did receive her medications including melatonin 9 mg. This nurse reminded resident that she did receive medications and administered this evenings medications. Resident states that she is still having difficulty sleeping."<br><br>A nursing progress note for Resident 30 (the roommate), dated 2/26/24 at 10:17 p.m., indicated Resident 30 was calling out, "help me, ow ow ow ow" at beginning of shift. Resident was transferred to wheelchair and came down to the | | | |

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| | dining area and socialized with peers. She initially refused dinner but then changed her mind. Upon return to her room, she began repeating "ow ow ow," music was turned on for resident and she was transferred to bed ..."<br><br>A nursing progress note for Resident 83, dated 2/27/24 at 9:22 p.m., indicated, "Staff reports that resident remained in bed most of the day. Resident self-care declining. Resident requiring more assistance...."<br><br>A nursing progress note for Resident 30 (the roommate), dated 2/28/23 at 8:56 p.m., indicated Resident 30 was noted to be crying and moaning in the common area before dinner. Her Peers expressed being disturbed ... she was taken back to her room as requested but continued to "admonish" staff. She turned her light on several times, and when assistance was offered, she declined. Resident 30 continued to keep her finger on call light and did not want to remove it. Resident 30 was encouraged to let it go, so that staff would know when she needed something. Resident 30 indicated she did not have her finger on it and had removed finger from soft touch call light.<br><br>A nursing progress note for Resident 83, dated 2/29/24 at 9:07 p.m., indicated Resident 83 attended dinner with peers and her appetite was fair. She returned to her room after dinner stating that she wanted to go to bed early.<br><br>A nursing progress note for Resident 30 (the roommate), dated 2/27/24 at 10:01 p.m., indicated Resident 30 was in the lounge area and called out, "ow ow ow ..." When resident was returned to her room after dinner she began calling out, "ow ow ow." | | | |

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A nursing progress note for Resident 30 (the roommate), dated 3/1/24 at 8:59 a.m., indicated the SSD followed up with Resident 30 as staff reported she had been up all night. Resident reported she was exhausted but did not remember being up all night.

A nursing progress note for Resident 30 (the roommate), dated 3/1/24 at 1:50 p.m., indicated Resident 30 was " ...yelling throughout the night, stayed in bed this shift per resident's request, resident asleep most of the day ..."

A nursing progress note for Resident 30 (the roommate), dated 3/2/24 at 8:59 p.m., indicated Resident 30 exhibited behaviors at this time spitting on staff, yelling, and refusing care/medications. Staff gave resident time and space within room ...."

A psychiatric provider progress note for Resident 83, dated 3/4/24, indicated, " ...staff notes she has been in bed more frequently. She states she has been wanting some time to herself ....Her melatonin was increased last visit, but she still had complaints of difficulty sleeping ...if this continues, we may decide to start her on a low dose of trazadone...." Staff indicated she had lost 3 pounds since the last visit, and they were concerned she may have further weight loss.

A nursing progress note for Resident 83, dated 3/4/24 at 9:37 p.m., indicated, "Resident is alert, pleasant and cooperative, attended dinner with peers. Resident returned to room and went to bed earlier than usual. This nurse entered to give medications and resident aroused without difficulty, resident did not voice any concerns when asked. Resident mood appears down, and

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| | she is less talkative this evening. Resident denies insomnia. No apparent side effects related to increase of melatonin dosage."<br><br>A nursing progress note for Resident 30 (the roommate), dated 3/4/24 at 9:40 p.m., indicated Resident 30 was up in wheelchair for dinner. Resident's appetite was good with 100% consumed. When Resident 30 was returned to her room after dinner she began yelling out, "help me, help me!"<br><br>A nursing progress note for Resident 30 (the roommate), dated 3/6/24 at 9:25 p.m., indicated Resident 30 took medications without difficulty and was assisted to her room and into bed. Resident 30 continued to call out and was difficult to redirect.<br><br>A nursing progress note for Resident 30 (the roommate), dated 3/7/24 at 7:22 p.m., indicated Resident 30 was yelling loudly before dinner, "OW OW OW!" She was brought to the dining room and resident stopped yelling. Resident 30 had dinner with assistance but continued to moan. Resident watched TV for a short time after dinner and then was taken to her room. Resident continued to yell loudly. This nurse assisted CNA with transfer and then attempted to administer medications without success... music was turned on, not able to redirect resident ... next shift will attempt to administer medication."<br><br>A nursing progress note for Resident 30 (the roommate), dated 3/12/24 at 9:06 p.m., indicated Resident 30 had been very angry all shift. Yelled at staff during dinner that she wanted someone to feed her then would yell, "Get away from me!" every time feeding efforts were made. Continued to yell at the preacher when he came for church. | | | |

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| | Then she was in her room moaning and howling.<br><br>A nursing progress note for Resident 30 (the roommate), dated 3/13/24 at 4:18 p.m., indicated Resident 30 refused medications and moaned and yelled throughout the shift.<br><br>A nursing progress note for Resident 30 (the roommate), dated 3/14/24 at 12:10 a.m., indicated Resident 30 was repeatedly saying "ow ow ow ow ow". When asked if she was in pain Resident 30 stated " oh no, this is just me."<br><br>A nursing progress note for Resident 30 (the roommate), dated 3/22/24 at 10:19 p.m., indicated after dinner Resident 30 began accusing the nurse of taking her children from her. This nurse listened to the resident's concerns and attempted to redirect without success. Resident called out "ow ow ow ow" and denied pain or discomfort. Resident was taken to her room.<br><br>A nursing progress note for Resident 30 (the roommate), dated 3/25/24 at 11:17 p.m., indicated Resident 30 yelled out repeatedly "ow ow ow," refused medications and was unable to console.<br><br>A nursing progress note for Resident 30 (the roommate), dated 3/27/24 at 2:57 p.m., indicated Resident 30 was crying & screaming that morning, she was put on bedpan per request, call light was placed in her hand and asked to press call light when finished. Approximately 10 minutes later resident began to cry and scream again. Resident 30 stated "there's a woman in the corner of my room." Resident 30 assured no one was in her room. She was dressed and transferred to wheelchair and then taken to day room with peers but continued to scream. When asked what was wrong, she stated "they're hurting me, this place | | | |

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| | is full of incompetent people, do you not see what's wrong?" She began to cry and moan inside dining room during lunch time. Several peers complained of her behavior. Resident 30 began screaming she wanted to be taken to her room.<br><br>A SSD progress note for Resident 83, dated 4/3/24 at 12:16 p.m., indicated the SSD visited with resident in hallway. Resident 83 was alert, orientated, calm, and pleasant. Resident talked about her disrupted sleep last night due to her roommates moaning and her worrying about her roommate. Resident voiced concerns about clinical staff wanting her to get up this morning. Resident reported because she did not get any sleep last night, she did not want to get up for breakfast. Resident 83 had a history of not wanting to get up in the mornings for breakfast. Resident 83 did get up at lunch time but reported she only ate a little of her lunch. Resident reported she "felt better" after talking to writer and getting her thoughts "off her chest." After resident spoke with writer, resident returned to playing Bingo. No anguish or distress noted. SS will continue to observe and remain available.<br><br>A nursing progress note for Resident 83, dated 4/3/24 at 1:15 p.m., indicated Resident 83 refused breakfast and slept through most of the day. She was awakened at lunch time but only accepted lunch meal in her room due to her complaint of fatigue and being unable to sleep through her neighbor's behaviors throughout the night and day.<br><br>A nursing progress note for Resident 30 (the roommate), dated 4/5/24 at 10:49 p.m., indicated Resident 30 was calling out moaning and stating "ow ow ow" but denied pain or discomfort when asked. Resident 30 called to another resident | | | |

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| | telling her to stand up from wheelchair. Resident was redirected and brought to dinner. Resident 30 later came to common area with peers to watch television and began calling out "ow ow ow." Multiple residents complained to resident and resident continued. Attempts to redirect were not successful. Music was turned on for the resident in her room, but she continued to call out.<br><br>A nursing progress note for Resident 30 (the roommate), dated 4/13/24 at 11:45 a.m., indicated Resident 30 did not have a good morning and had several outbursts and had episodes of yelling, crying, screaming out.<br><br>On 4/22/24 at 10:35 a.m., an interview was conducted with the SSD. The SSD indicated according to the room-move and/or intra-facility transfer policy and procedure, the Resident that would be moving to a new room was required to receive at least a 48-hour notice, but Resident 30's family had waived that right. The resident who was receiving a new roommate should also be made aware or notified that they were receiving a new roommate. It was also advisable to set up "meet-and-greet" opportunities before moving two people in together. The SSD indicated she could not remember if she let Resident 83 know that she was going to get a new roommate, if she did, she would have made a progress note about it. After the room move was completed, the Social Service department should also do psychosocial follow up for at least 3-5 days for both roommates regarding the move. The SSD indicated she did not remember specific visits for follow up with Resident 83 about the roommate, but she visited with the resident on an almost daily basis. The SSD indicated Resident 30 was a difficult patient and that no other nursing home would take her because of her behaviors. The facility has worked | | | |

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| | very hard to address and accommodate her behaviors however, she continued to yell and call out and make false allegations and accusations. The SSD indicated Resident 83 was a highly sensitive person and because she had been a CNA before, she often felt obligated to help her roommate. Resident 83 indicated she felt that others would be upset with her if she did not help. As far as not being able to sleep, the SSD indicated it was normal for her to want to sleep in. The SSD indicated Resident 83 never complained directly to her about her roommate and if she did complain Resident 83 would deny or refuse assistance upon follow-up to the concern. A long-term goal would be to move Resident 83 in with her best friend or have her best friend (that lived across the hall) move in with her, but the beds were very hard to come by and the SSD was not sure when or if that could happen.<br><br>On 4/22/24 at 11:30 a.m., the Executive Director (ED) provided a copy of current facility policy, dated 11/2014. The policy indicated, " ...The Resident's welfare is our number one priority and following CarDon's transfer or discharge guidelines allows all parties to safeguard our residents ... an intrafacility transfer only occurs if: 1) the transfer is necessary for medical reasons as judged by the attending physician, or 2) the transfer is necessary for the welfare of the resident or other persons ... The planning conference includes the following: 1) a review of the resident's medical, psychosocial, and social needs with respect to the relocation. A plan will be formulated to meet these needs. 2) the facility shall provide reasonable assistance to the resident and related individuals to carry out the relocation plan. 3) the facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge | | | |

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| | from the facility ...."<br><br>A review of the State Operations Manual (SOM) Appendix PP, revised 2/3/23 indicated, " ...Moving to a new room or changing roommates is challenging for residents. A resident's preferences should be taken into account when considering such changes. When a resident is being moved at the request of facility staff, the resident, family, and/or resident representative must receive an explanation in writing of why the move is required. The resident should be provided the opportunity to see the new location, meet the new roommate, and ask questions about the move ...."<br><br>3.1-3(a)<br>3.1-3(v)(1)<br>3.1-3(v)(2) | | | |
| F 0558 SS=D Bldg. 00 | 483.10(e)(3)<br>Reasonable Accommodations Needs/Preferences<br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>Based on observation, interview, and record review, the facility failed to ensure that a call device was within reach for 1 of 1 random observation for call lights (Resident 36).<br><br>Findings include:<br><br>On 4/17/24 at 1:27 p.m., during a random observation in the hallway, Resident 36 was heard as she called out for help. She was observed to be upright in a wheelchair with the wheels locked and pressure-relieving boots on both feet. The | F 0558 | The plan of correction is to serve as Cumberland Trace's credible allegation of compliance.<br><br>Submission of this plan of correction does not constitute an admission by Cumberland Trace and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing | 05/20/2024 |

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| | bedside table was in front of her with a lunch tray which sat on top. The resident faced towards the television, away from her bed. She indicated she needed someone to get a staff member for her because she did not have her call light. The call light was out of view and out of reach on top of the bed behind her. When asked how long she had been without her call light, she indicated it had been since she had her bed bath that morning at 11:00 a.m., because they forgot to give it to her when they were done. She indicated staff had not provided her call light when they brought her lunch.<br><br>On 4/19/24 at 9:50 a.m., Resident 36's record was reviewed. She had a diagnoses which included, but were not limited to, muscle weakness, unsteadiness on feet, abnormalities of gait (the pattern you walk) and mobility (ability to move), stage two pressure ulcer (damage to a deeper area of the skin caused by constant pressure on the area for a long time) on left heel, non-pressure chronic (long-lasting) ulcer of right ankle with unspecified severity, left hand contracture (permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff), lack of coordination (muscle control problem), and age-related physical debility (physical decline).<br><br>A quarterly Minimum Data Set (MDS) assessment, edited 1/19/24, indicated Resident 36 had a Brief Interview for Mental Status (BIMS) score of 14, that indicated the resident was cognitively intact. The MDS also indicated she had a functional limitation in range of motion with upper and lower extremity impairment on one side.<br><br>A comprehensive care plan, revised 4/15/24, indicated Resident 36 experienced urge/functional | | care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.<br><br>**F 558 –** Facility failed to ensure that a call device was within reach.<br><br>**I. The corrective actions to be accomplished for those residents found to have been affected by the practice.**<br><br>The call light for Resident 36 was placed within reach. Resident 36 suffered no ill effects from this alleged deficient practice.<br><br>**II. The facility will identify other residents that may potentially be affected by the practice.**<br><br>**III. The facility will put into place the following systematic changes to ensure that the practice does not recur.**<br><br>**IV. The facility will monitor the corrective action by implementing the following measures.** | |

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| | bladder incontinence (uncontrolled urination), and needed assistance with toileting. Interventions included, but were not limited to, leaving call lights close at hand. The care plan indicated that she was unable to independently perform activities of daily living related to a history of fracture (broken bone) of her right lower leg, muscle weakness, vitamin deficiency, and lymphedema (swelling related to the body's lymphatic system). Interventions included, but were not limited to, keeping call light within reach. The care plan indicated that she was at risk for falling and fall related injuries due to her history of right ankle fracture, increased weakness, and decreased mobility. Interventions included, but were not limited to, encouraging the resident to utilize her call light to seek assistance as needed.<br><br>During an interview on 4/17/24 at 1:38 p.m., Certified Nursing Aide (CNA) 20 indicated she had given Resident 36 a complete bed bath at 11:00 a.m. that morning. CNA 27 assisted with the Hoyer transfer (a machine used to lift and move residents with limited mobility), because it took two people to operate. She indicated that after she was done assisting her, another resident wanted to go to the bathroom that was calling out for them because their call light had been on. CNA 20 indicated she quickly left and assisted the other resident, and probably left the call device in Resident 36's bed. She indicated that it was close to lunch time, they finished serving lunch at 12:45 p.m. and whoever brought Resident 36 her lunch tray did not give her the call device either. CNA 20 indicated that normally, when they served Resident 36, they clipped the call device to her shirt, put the trashcan beside her chair, offered her donuts that she liked, and after lunch, she liked to get her electronic tablet. | | The DON, or designee, will round the facility to ensure call lights are within reach daily for 30 days, then weekly for 60 days, then monthly for 9 months for a total of 12 months of monitoring.<br><br>The results of the audits will be discussed in the facility monthly QAPI committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of the reviews will be adjusted as needed if compliance is below 100%.<br><br>**V. Plan of Correction completion date.**<br><br>Date of Compliance: 5/20/24<br>The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed. | |

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| | During an interview on 4/23/24 at 10:07 a.m., the Regional Clinical Specialist (RCS) indicated that every resident's care plan indicated that call lights should be within reach.<br><br>During an interview on 4/23/24 at 9:57 a.m., the Administrator (ADM) asked what time frame the resident went without her call device and indicated that someone would have taken her lunch tray to her and checked on her. It was noted that the resident still did not get her call light after the lunch tray was delivered.<br><br>During an interview on 4/23/24, the ADM indicated that they did not have a policy related to call devices being within reach, it was a standard of care.<br><br>3.1-3(v)(1) | | | |
| F 0686<br>SS=D<br>Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>Based on observation, interview, and record review, the facility failed to ensure timely | F 0686 | The plan of correction is to serve as Cumberland Trace Health and | 05/20/2024 |

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| | assessment and treatment of a resident's new open areas on the skin for 1 of 4 residents reviewed for pressure ulcer treatments and services (Resident 93).<br><br>Findings include:<br><br>On 4/15/24 at 10:14 a.m., Resident 93's room was observed. A white dry-erase board was observed on top of her wheelchair, leaning against the wall, with a note from family that indicated the resident had a stage 4 (full thickness skin loss with considerable tissue loss and may have muscle, bone, tendon or joint involvement) pressure ulcer, needed to have a pillow under the side of her lower back, and needed to be rotated to opposite side every two hours.<br><br>On 4/19/24 at 11:40 a.m., Resident 93's record was reviewed. As of 4/19/24, Resident 93 had a diagnoses which included, but were not limited to, stage 4 pressure ulcer, local infection of the skin, contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of the left upper arm, contracture of muscles in multiple sites, dementia (disease affecting memory, thinking, and social abilities), attention and concentration deficit (difficulty paying attention and staying focused), and uninhibited neuropathic bladder (difficulty with bladder management).<br><br>She had a physician's order, dated 11/21/23 - 3/27/24, which gave instructions to administer Juven (a medical food to support wound healing), 1 packet mixed with 8 ounces of fluid of choice, orally, twice a day for diagnosis of unstageable pressure ulcer. | | Living Community's credible allegation of compliance.<br><br>Submission of this plan of correction does not constitute an admission by Cumberland Trace Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.<br><br>**F 686**<br><br>**I. The corrective actions to be accomplished for those residents found to have been affected by the practice.**<br><br>Resident 93 did not suffer any ill affects related to the alleged deficient practice.<br><br>**II. The facility will identify other residents that may potentially be affected by the practice.**<br><br>Other residents with wounds were observed to ensure physician ordered treatments were in place.<br><br>**III. The facility will put into** | |

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| | 155836 | A. BUILDING 00<br>B. WING | 04/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| CUMBERLAND TRACE HEALTH & LIVING COMMUNITY | 1925 REEVES ROAD<br>PLAINFIELD, IN 46168 |

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| | A progress note, dated 11/15/23 at 12:56 p.m., indicated, the Resident had a new, stage 2 (partial thickness loss of skin presenting as a shallow open ulcer with a red or pink wound bed), open area on her right buttock and coccyx and that the Director of Nursing, Assistant Director of Nursing, and Unit Manager, were all made aware.<br><br>Resident 93's record lacked documentation of progress notes, nursing notes, notice of physician notification, skin assessment, orders, wound care notes, or other documentation related to the new open area between 11/15/23 and 11/20/23.<br><br>A progress note, dated 11/20/23 at 10:56 a.m., indicated the Resident had been seen by the wound team for reports of an area to the sacral region. The wound was classified as unstageable with etiology of pressure. Measurements were 8 centimeters (cm) length, 9 cm width, and 0.1 cm depth.<br><br>A comprehensive care plan, initiated 11/20/23, indicated Resident 93 had a stage 4 pressure ulcer to her sacrum. Interventions included, but were not limited to, pressure reducing cushion in wheelchair and low air loss pressure relieving mattress. Staff were to notify the physician if the area worsened, showed signs or symptoms of infection, or had increased pain, assist residents with turning and repositioning, administer treatments as ordered and administer supplements/vitamins as ordered to promote wound healing.<br><br>She had a physician's order, dated 3/12/24, which gave instructions to cleanse sacral wound with normal saline, pat dry, pack wound with fluffed gauze dampened with Dakin's 0.25 % solution (topical wound care solution), squeeze out excess, | | **place the following systematic changes to ensure that the practice does not recur.**<br><br>Licensed nursing staff are being educated regarding assessment of wounds and implementing physician orders related to wound care treatments and documentation of treatment completion.<br><br>**IV. The facility will monitor the corrective action by implementing the following measures.**<br><br>The Director of Nursing, or designee, will audit residents with wounds to ensure MD notification and treatments are ordered upon the identification daily for 4 weeks, then weekly for 8 weeks, then monthly for 3 months, then quarterly ongoing.<br><br>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.<br><br>**V. Plan of Correction** | |

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| | apply skin prep (liquid that when applied to the skin forms a protective film or barrier on the skin) to wound edges, and cover with padded foam dressing every shift and as needed (PRN) for soilage or dislodgement.<br><br>During an interview on 4/19/24 at 12:05 p.m., the Regional Clinical Specialist (RCS) indicated no additional documentation related to Resident 93's wound from between the 11/15/23 and 11/20/23 was found.<br><br>On 4/23/24 at 10:10 a.m., the Administrator (ADM) provided document, dated 2/1/19, titled, "Skin Assessment Policy," and indicated it was the policy currently being used by the facility. The policy indicated, " ...If a new skin condition is identified by a licensed nurse while completing a skin assessment, the nurse will open the appropriate [Skin Integrity Event] in Matrix and complete all required sections. The licensed nurse that discovers a new open area will perform the following actions: 1. Notify the MD, obtain and enter a treatment order 2. Apply the initial treatment 3. Notify the family 4. Inform other caregivers to ensure preventative interventions actions are put into place to promote healing and inhibit development of additional areas 5. Document these items in the medical record ...."<br><br>3.1-40(a)(1)<br>3.1-40(2)(2) | | **completion date.**<br><br>Date of Compliance: 5/20/24<br>The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed. | |
| F 0695 SS=D Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including | | | |

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| | tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br><br>Based on observation, interview and record review, the facility failed to follow physician orders for oxygen administration and storage of oxygen equipment provided to 2 of 2 residents reviewed for oxygen administration (Residents 70 and 261).<br><br>Findings include:<br><br>1. On 4/18/24 at 10:33 a.m., during an observation and interview, Resident 70. The call light was on, and the resident was observed sitting in a wheelchair next to the bed, the resident indicated she had been coughing and was short of breath. A liquid oxygen tank was on the opposite side of the bed with oxygen tubing attached to the tank and placed under the bed and attached to a nasal cannula (NC) tubing, (a medical device to provide supplemental oxygen therapy to people who have lower oxygen levels). The NC was placed in the nostrils of the resident. Observation of the oxygen tank indicated the liter flow dial was set at 0, indicating there was no oxygen flowing from the oxygen tank to the resident.<br><br>The resident indicated the Certified Nurse Aide (CNA), placed the oxygen NC tubing on her when she returned from breakfast at 9:30 a.m. The resident indicated she had turned on her call light to ask for assistance to go to the restroom and she was not aware the oxygen tank had not been providing oxygen for the previous hour and stated, "that explains why I can't breathe." | F 0695 | The plan of correction is to serve as Cumberland Trace's credible allegation of compliance.<br><br>Submission of this plan of correction does not constitute an admission by Cumberland Trace and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.<br><br>**F-695:** Facility failed to ensure residents receive necessary respiratory care and services in accordance with professional standards of practice.<br><br>**I. The corrective actions to be accomplished for those residents found to have been affected by the practice.**<br><br>1. Resident 70's oxygen was administered by a nurse, and | 05/20/2024 |

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| | At 10:35 a.m., Licensed Practical Nurse (LPN) 59, came into the room and checked the NC. Upon verification that oxygen was not being administered to the resident, he turned the liter flow dial to 4, indicating the flow rate to be 4 L (liters). He asked the resident if she could feel the oxygen. The resident indicated yes, and the LPN told the resident she was good. At 10:40 a.m., LPN 201 came into the room and asked the resident if she was ok.<br><br>The nurses failed to assess the resident or assess the oxygen level at the time of observation.<br><br>On 4/18/24 at 10:40 a.m., during an interview with CNA 64, she indicated she had applied the oxygen tubing to the resident when the resident returned from the dining room around 9:30 a.m. She indicated she turned the oxygen flow dial on the liquid oxygen tank to 5 and placed the NC tubing on the resident.<br><br>On 4/18/24 at 10:50 a.m., during an interview with employee 201, she indicated a CNA was not allowed to turn on oxygen or adjust the liter flow. She indicated a CNA was allowed to apply the NC tubing on the resident.<br><br>On 4/18/24 at 11:30 a.m., observation of the resident indicated the resident was no longer short of breath and indicated she was feeling much better.<br><br>On 4/18/24 at 11:33 a.m., during an interview with the Regional Nurse Consultant she indicated the CNA was not allowed to adjust the liter flow of oxygen and was not allowed to initiate oxygen. They were only allowed to transfer and apply tubing. | | orders were verified. Resident 70 suffered no ill effects from this alleged deficient practice.<br>2. Oxygen tubing was replaced and dated with the current date. Resident E suffered no ill effects from this alleged deficient practice.<br><br>**II. The facility will identify other residents that may potentially be affected by the practice.**<br><br>All resident that utilize oxygen have the potential to be affected by this alleged deficient practice. The DON/designee will monitor/audit residents utilizing oxygen to ensure proper oxygen administration and labeling and storage of oxygen equipment.<br><br>**III. The facility will put into place the following systematic changes to ensure that the practice does not recur.**<br><br>DON or designee will re-educate all staff on oxygen administration and dating and labeling of oxygen devices and storage when they're not in use<br><br>**IV. The facility will monitor the corrective action by implementing the following** | |

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| | On 4/18/24 at 2:18 p.m., during an interview with Employee 117, she indicated they were not allowed to adjust the oxygen of a resident. If the oxygen was not on, she would notify the nurse to put it on. She indicated she was not allowed to turn on the oxygen because oxygen is a medication.<br><br>On 4/18/24 at 2:30 p.m., the medical record for Resident 70 was reviewed. The resident was admitted to the facility on 3/22/24. Diagnosis included but were not limited to, acute and chronic respiratory failure with hypoxia (low levels of oxygen in your body tissues. It causes symptoms like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin), chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), chronic congestive heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), chronic pulmonary histoplasmosis (a lung infection caused by breathing in Histoplasma, a fungus that lives in the environment in certain parts of the United States and the world), Type 2 diabetes mellitus without complications (a disease that occurs when your blood glucose, also called blood sugar, is too high).<br><br>Physician Orders included but were not limited to albuterol sulfate HFA aerosol inhaler; 90 mcg (micrograms)/actuation; amount: 2 puffs; inhalation Every 4 Hours - as needed (PRN)<br>Budesonide suspension for nebulization; 0.5 mg (milligrams) / 2 mL (milliliters) administer 2 ml; inhalation Twice a Day<br>Ipratropium-albuterol solution for nebulization; 0.5 mg-3 mg (2.5 mg base)/3 mL; administer 3 ml; inhalation Every 6 Hours. | | **measures.**<br><br>The DON/designee will monitor/audit residents utilizing oxygen weekly times 4 weeks, then biweekly for 8 weeks, then monthly for 9 months to ensure proper oxygen administration and labeling and storage of oxygen equipment.<br>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%.<br>Frequency and duration of reviews will be increased as needed, if compliance is below 100%.<br><br>**V. Plan of Correction completion date.**<br><br>Date of Compliance: 5/20/24<br>The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed. | |

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| | May titrate (adjust) oxygen (2-5 liter/minute) to maintain sats (oxygen saturation, the amount of oxygen in the blood) greater than 90%. Every Shift.<br>Change and date oxygen tubing, humidifier bottle and nebulizer tubing. Change weekly and PRN Once a day on Sun<br>Elevate head of bed as tolerated to alleviate shortness of breath while lying flat. Diagnosis of COPD, acute on chronic respiratory failure. Every Shift.<br><br>An MDS assessment dated 3/25/24, indicated the resident was cognitively intact and was receiving oxygen during the look back assessment period.<br><br>A care plan dated 3/25/24, indicated the resident had potential for respiratory distress related to COPD, acute, chronic respiratory failure, and pulmonary histoplasmosis. Interventions included but were not limited to, administer oxygen per MD (medical doctor) order.<br><br>2. 4/15/24 at 10:53 a.m., during routine observation of Resident 261. The Resident was observed lying in bed with oxygen NC tubing placed and liter flow set at 3.5 Liters. Observed undated tubing and humidifier bottle.<br><br>4/16/24 at 10:16 a.m., routine observation of the Resident indicated undated oxygen tubing and humidifier bottle. Oxygen administered by NC at 4L.<br><br>4/16/24 at 10:37 a.m., during interview with Registered Nurse (RN) 186. The RN indicated, the oxygen tubing, humidity bottle and storage bag must be dated each time the equipment is changed. | | | |

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| | 4/17/24 at 1:59 p.m., during routine observation, the Resident observed sitting up in bed with oxygen on per NC at 3.5 liters. No date on tubing or on the humidity bottle.<br><br>On 4/15/24 at 11:00 a.m., the medical record for Resident 261 was reviewed. The resident was admitted to the facility on 4/9/24. Diagnosis included but were not limited to, chronic congestive heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), Unspecified atrial fibrillation (an irregular heart rhythm (arrhythmia) that begins in the upper [atria] of your heart), hypokalemia (low potassium), depression (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks), chronic obstructive pulmonary disease, (a group of diseases that cause airflow blockage and breathing-related problems), type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high).<br><br>Physician orders included but were not limited to,<br>albuterol sulfate aerosol inhaler; 90 mcg/actuation; administer 1 puff; inhalation Twice a Day<br>albuterol sulfate solution for nebulization; 2.5 mg /3 mL (0.083 %); administer 1 vial; inhalation Every 8 Hours - PRN<br>Oxygen (4 liter/min) continuous per (nasal cannula) Every Shift<br>Change and date oxygen tubing, humidifier bottle and nebulizer tubing, Change weekly and PRN Once a Day on Sun.<br><br>An admission MDS assessment dated 4/12/24, the resident was cognitively intact and indicated | | | |

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| | oxygen was administered continually during the assessment period.<br><br>A care plan dated 4/9/24 indicated the resident was at risk for impaired gas exchange and required oxygen therapy. The interventions included but were not limited to. Administer oxygen as ordered.<br><br>On 4/19/24 at 9:19 a.m., the Administrator provided an undated document, titled, "Administering Medications," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy Statement: Medications shall be administered in a safe and timely manner and as prescribed ...3. Medications must be administered in accordance with the orders, including any required time frame ...."<br><br>On 4/19/24 at 9:20 a.m., the Administrator provided a document titled, "Oxygen Administration skills validation, dated, 10/26/17 and indicated it was the policy currently being used by the facility. The policy indicated ...2. c. tubing/extension tubing ...e. humidification ... h. Tape-for labeling the date and initials of the preparer ...."<br><br>3.1-47(a)(4)(5)(6) | | | |
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00427629.<br><br>Complaint IN00427629 - No deficiencies related to the allegations are cited. | R 0000 | | |

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| | Survey dates: April 15, 16, 17, 18, 19, 22, and 23, 2024.<br><br>Facility number: 013455<br><br>Residential Census: 61<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on May 3, 2024. | | | |
| R 0243<br><br>Bldg. 00 | 410 IAC 16.2-5-4(e)(3)<br>Health Services - Deficiency<br>(3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the:<br>(A) time;<br>(B) name of medication or treatment;<br>(C) dosage (if applicable); and<br>(D) name or initials of the person administering the drug or treatment.<br>Based on interview and record review, the facility failed to document medication administration or a reason for not giving a medication for 1 of 1 residents reviewed for medication administration (Resident 5).<br><br>Findings include:<br><br>On 4/22/24 at 10:00 a.m., during an interview, Resident 5 indicated he did not receive his insulin last evening and there were other times he had not received his evening dose of insulin.<br><br>Resident 5's medical record was reviewed on 4/22/24 at 11:30 a.m.. The resident was admitted to the facility on 9/4/19. Admitting diagnosis included, but were not limited to, post myocardial | R 0243 | The plan of correction is to serve as Cumberland Trace's credible allegation of compliance.<br><br>Submission of this plan of correction does not constitute an admission by Cumberland Trace and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. | 05/20/2024 |

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| | infarction (heart attack), macular degeneration (an eye disease that can blur your central vision), type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), atrial fibrillation (an irregular heart rhythm that begins in the upper [atria] of your heart), and congestive heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs).<br><br>Physician's orders included, but were not limited to, glargine insulin pen 100 unit/mL (milliliters) administer 45 units subcutaneous (under the skin) twice a day for diagnosis of type 2 diabetes.<br><br>The medication administration record indicated the insulin was not signed as being administered on 3/4/24 evening dose, 3/21/24 morning dose, 3/22/24 evening dose, 3/30/24 and 3/31/24 evening doses, 4 2/24 evening dose, 4/4/24 evening dose, 4/9/24 morning dose, and 4/11/24 evening dose.<br><br>The medical record lacked documentation of the medication being held or physician notification of medication not being administered. | | **R 243 –** The facility failed to document medication administration or reason for not giving a medication.<br><br>**I. The corrective actions to be accomplished for those residents found to have been affected by the practice.**<br><br>Resident 5 suffered no ill effects from this alleged deficient practice.<br><br>**II. The facility will identify other residents that may potentially be affected by the practice.**<br><br>All residents that receive medication administration from the facility are at risk of the alleged deficient practice. The DON/designee will monitor/audit residents receiving medication administration from the facility to ensure orders are being followed.<br><br>**III. The facility will put into place the following systematic changes to ensure that the practice does not recur.**<br><br>DON or designee will re-educate all nurses and QMAs on following physician orders and administering medications. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155836 | A. BUILDING 00<br>B. WING | 04/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CUMBERLAND TRACE HEALTH & LIVING COMMUNITY | 1925 REEVES ROAD<br>PLAINFIELD, IN 46168 |

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|---|---|---|---|---|
| | | | **IV. The facility will monitor the corrective action by implementing the following measures.**<br><br>The DON/designee will monitor/audit resident medication administration weekly times 4 weeks, then biweekly for 8 weeks, then monthly for 9 months to ensure proper oxygen administration and labeling and storage of oxygen equipment.<br><br>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%.<br>Frequency and duration of reviews will be increased as needed, if compliance is below 100%.<br><br>**V. Plan of Correction completion date.**<br><br>Date of Compliance: 5/20/2024<br>The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed. | |