

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013455	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/14/2024
NAME OF PROVIDER OR SUPPLIER CUMBERLAND TRACE HEALTH & LIVING COMMUNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 1925 REEVES ROAD PLAINFIELD, IN 46168		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on April 23, 2024.</p> <p>Survey dates: June 14, 2024</p> <p>Facility number: 013455</p> <p>Residential Census: 62</p> <p>Cumberland Trace Health & Living Community was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey.</p> <p>Quality review completed on June 27, 2024.</p>	{R 000}		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE