

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/06/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155836		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 05/21/2024	
NAME OF PROVIDER OR SUPPLIER CUMBERLAND TRACE HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP COD 1925 REEVES ROAD PLAINFIELD, IN 46168			
(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: 05/21/24 Facility Number: 013455 Provider Number: 155836 AIM Number: 201293440 At this Emergency Preparedness survey, Cumberland Trace Health and Living Community was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 104 certified beds. At the time of the survey, the census was 91. Quality Review completed on 05/22/24			E 0000			
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). Survey Date: 05/21/24 Facility Number: 013455 Provider Number: 155836 AIM Number: 201293440 At this Life Safety Code survey, Cumberland			K 0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Trei Barnett

Administrator

05/31/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosable 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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K 0291 SS=E Bldg. 01	<p>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.</p> <p>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 and has hard wired smoke detectors installed in all resident rooms. The facility has a capacity of 104 and had a census of 91 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached storage building which was not sprinklered.</p> <p>Quality Review completed on 05/22/24</p> <p>NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 4 of 4 battery backup lights were tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages, and a written record of visual inspections and tests was provided. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with</p>			K 0291	<p>May29, 2023</p> <p>Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street</p>		05/25/2024

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	<p>Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review on 05/21/24 at 10:07 a.m. with the Maintenance Director and the Regional Maintenance Director, there was no Battery-Operated Emergency Light Test Log for 2024. On January 1st of 2024, the Maintenance Director installed two battery operated lights in the facility. Based on an interview at the time of record review, the Maintenance Director advised that he was unaware of the need for testing of these lights but added that he would make a battery-operated emergency lighting testing log and begin testing these lights as soon as possible.</p> <p>This item was discussed at the exit conference with the Maintenance Director and the Regional Maintenance Director on 05/21/24 at 2:06 p.m.</p> <p>3.1-19(b)</p>				<p>Indianapolis, IN 46204</p> <p>Re: Allegation of Compliance</p> <p>Event ID: DH2X21</p> <p>Dear Mrs. Buroker:</p> <p>Please find enclosed the Plan of Correction for the State Licensure Survey conducted on May 21, 2024. This letter is to inform you that the plan of correction attached is to serve as Cumberland Trace Health and Living Community credible allegation of compliance. We allege substantial compliance on May 25, 2024. We are requesting paper compliance for this plan of correction.</p> <p>If you have any further questions, please do not hesitate to contact me at 317-838-7070.</p> <p>Sincerely,</p> <p>Trei Barnett, HFA Administrator Cumberland Trace</p> <p>Submission of this plan of correction in no way constitutes</p>		

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			<p>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 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.</p> <p>This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.</p> <p>K 291</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Observation 1– The Community failed to ensure that 4 battery powered emergency lights we inspected weekly and for 90 minutes annually. The Maintenance Supervisor has created a log for documenting these items. A new TELS task</p>		

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			<p>for weekly testing and an annual 90-minute functionality test were created. See attached TELS tasks.</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>All staff and residents have the potential to be affected by this deficient practice.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>Observation 1- A new TELS task for weekly testing and an annual 90-minute functionality test were created. See attached TELS tasks labeled "Cumberland Weekly Emergency Lighting Task" and "Cumberland Annual Emergency 90 Min Run Test."</p> <p>IV The facility will monitor the corrective action by implementing the following measures.</p>		

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					<p>CarDon Corporate facilities will inspect the emergency lighting logs during their annual Corporate Quality Review to ensure the frequency and documentation is being met.</p> <p>V. Plan of Correction completion date.</p> <p>Plan of Completion date is May 25th, 2024.</p>		