STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155775	A. BUILDING -- B. WING	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CUMBERLAND POINTE HEALTH CAMPUS	1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906

(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: 07/01/24 Facility Number: 000547 Provider Number: 155775 AIM Number: 100267440 At this Emergency Preparedness survey, Cumberland Pointe Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 71 certified beds. At the time of the survey, the census was 55. Quality Review completed on 07/03/24	E 0000	The submission of this plan of correction does not indicate an admission by Cumberland Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Cumberland Health Campus.¿ ¿ The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility.¿ It is thus submitted as a matter of statute only.¿ The facility respectfully requests from the department a desk review for substantial compliance.¿	
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: 07/01/24 Facility Number: 000547 Provider Number: 155775 AIM Number: 100267440 At this Life Safety Code survey Cumberland	K 0000	The submission of this plan of correction does not indicate an admission by Cumberland Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Cumberland Health Campus.¿ ¿ The facility hereby maintains it is in substantial compliance with all	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carol Ward	ED/ HFA	07/15/2024

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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	Pointe Health Campus was found not in compliance with Requirements for Participation in 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 facility was determined to be of Type V (111) construction and was fully sprinklered. The certified health care beds in this facility were located on the east and west wings of a one-story building. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered detectors in 19 east wing resident rooms and hard-wired smoke detectors in 23 west wing resident rooms. The facility has a capacity of 71 and had a census of 55 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 07/03/24		state and federal requirements governing the management of this facility.¿ It is thus submitted as a matter of statute only.¿ The facility respectfully requests from the department a desk review for substantial compliance.¿	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure 9 of 9 fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air	K 0521	K521 – HVAC Immediate Intervention Facilities Management Support was able to contact the vendor (Safe Care), to provide the campus with a copy of the 4-year damper	07/02/2024

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	conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review on 07/01/24 at 11:36 a.m. with the Director of Plant Operations (DPO) and Facility Maintenance Support (FMS), the Fire/Smoke Damper Maintenance Testing Record indicated that there were nine fire dampers located throughout the facility. The only testing documentation that could be provided for review was dated 05/24/2019 and was well over the four-year testing requirement. The lack of a current four-year maintenance document conducted on the fire dampers located throughout the facility was verified by the FMS at the time of record review who added that he was sure the		testing document that was completed on 6/19/2024. That was not available during the time of the survey. The Director of Plant Operations was educated by the Executive Director on NFPA 101, 2012 edition, NFPA 80, 2010 edition 19.4.1 Each damper shall be tested and inspected 1 year after installation & 19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years. All damper testing documentation will be uploaded into the TELS, Task/Work Order software. The Original copy of the documentation will be filed in the campus binder titled Life Safety. The Executive Director will review the Life Safety binder with The Director of Plant Operations 1 time per month times 3 months for completion, deficiencies, and accuracy. The results of the monthly review will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, staff and visitors in the campus.	

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	testing was completed but could not reach the vendor to request another copy of the testing documentation as of the time of this survey. This item was again discussed at the exit conference with the DPO and the FMS on 07/01/24 at 1:45 p.m. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure in 1 of 1 conference room flexible	K 0920	K920 Electrical Equipment- Power cords and Extension	07/02/2024

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	cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect as many as 8 staff. Findings include: Based on observations made on 07/01/24 at 9:16 a.m. with the Director of Plant Operations (DPO), there was a power strip plugged into a table lamp in the facility conference room. When this power strip was pointed out, the DPO immediately walked over to it and unplugged it from the wall removing it from use. Based on interview at the time of the observation, the DPO stated staff knows that power strips are not allowed to be used as extension cords. This item was again discussed at the exit conference with the DPO and the FMS on 07/01/24 at 1:45 p.m. 3.1-19(b)		Immediate Intervention The DPO (Director of Plant Operations) removed all power cords and will round rooms, offices and common areas 3x per week to ensure there's no power strips or extension cords. Corrective Action: The Director of Plant Operations immediately removed the power strip from the Assisted Living private dining room. The Director of Plant Operations or designee will round all rooms, offices and common areas weekly x 3 months to ensure compliance or until 100% compliance is maintained. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	