STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155841	A. BUILDING 00 B. WING	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COPPER TRACE HEALTH & LIVING COMMUNITY	1250 W 146TH STREET WESTFIELD, IN 46074

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Complaint IN00449971. Complaint IN00449971 - No deficiencies related to the allegations are cited. Survey dates: January 2, 3, 6, 7 and 8, 2025. Facility number: 013556 Provider number: 155841 AIM number: 201341880 Census Bed Type: SNF: 26 SNF/NF: 73 Residential: 65 Total: 164 Census Payor Type: Medicare: 5 Medicaid: 50 Other: 44 Total: 99 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on January 14, 2025.	F 0000	**This plan of correction is to serve as CopperTrace Health and Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Copper 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 and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **CopperTrace Health and Living is respectfully requesting that Paper Compliance be considered for this Plan of Correction.**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility	F 0684	F684	01/26/2025

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

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	failed to ensure a blood pressure medication was held according to the physician's ordered hold parameter, to give an ordered antibiotic prior to a dental visit, and to treat an elevated blood sugar with the physician's ordered sliding scale for 3 of 3 residents reviewed for quality of care. (Resident 256, 4 and 52) Finding includes: 1. The clinical record for Resident 256 was reviewed on 1/2/25 at 10:29 a.m. The diagnoses included, but were not limited to, anemia, essential primary hypertension, and memory deficit following other cerebrovascular disease. A physician's order, dated 12/27/24, indicated to give lisinopril (a medication to lower blood pressure) 10 milligrams (mg) tablet once a day, with special instructions to hold the medication for a systolic blood pressure less than 140. A Medication Administration Record (MAR), dated 12/27/24 through 1/7/25, indicated lisinopril 10 mg was not held according to the physician's order on the following dates: a. On 12/28/24, with a systolic blood pressure of 132. b. On 12/31/24, with a systolic blood pressure of 112. c. On 1/1/25, with a systolic blood pressure of 124. d. On 1/5/25, with a systolic blood pressure of 137. e. On 1/6/25, with a systolic blood pressure of 108. f. On 1/7/25, with a systolic blood pressure of 134. The electronic medical record did not include documentation the physician had been notified of the lisinopril administrations when the systolic blood pressure was below the hold parameter of 140.		Resident 256 blood pressure readings were reviewed by the NP with no new orders. Resident 4 received the antibiotic prior to dental visit. The nurse did not sign it off on the eMAR. The nurse has been re-educated on the importance of signing medications off on the eMAR. Resident 52 blood sugars have been reviewed by the NP with no new orders. Residents with hold parameters for blood pressure medications have the potential to be affected by the alleged deficient practice. Orders for the last 30 days have been reviewed to ensure the medications have been held per MD orders. Residents with orders for antibiotics prior to dental visits have the potential to be affected by the alleged deficient practice. The orders for the last 30 days for antibiotic prior to dental visits have been audited to ensure the nurse has signed them off on the eMAR. Residents with sliding scale orders have the potential to be affected by the alleged deficient practice. Orders for the last 30 days have been audited to ensure elevated blood sugars have been treated according to the sliding scale. Licensed nurses and QMAs were educated regarding following	

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	During an interview, on 1/7/25 at 11:55 a.m., RN 7 indicated the staff initials would be in parenthesis on the MAR when the medication had not been given. If there were no parenthesis around the initials, then the medication had been given. During an interview, on 1/7/25 at 3:00 p.m., the Director of Nursing (DON) indicated the lisinopril dose was given on the listed dates against the physician's ordered hold parameter.2. The clinical record for Resident 4 was reviewed on 1/3/25 at 12:16 a.m. The diagnoses included, but were not limited to, angina pectoris, chronic artery disease, congestive heart disease, hypertension, myasthenia gravis, depression, and anxiety disorder. A physician's order, dated 12/17/24, indicated azithromycin (an antibiotic) 500 mg (milligrams) tablet was to be given prior to dental appointments and cleanings. A progress note, dated 12/17/2024 at 2:02 p.m., indicated the resident was seen by the dental hygienist on 12/17/24. The resident's Medication Administration Record (MAR) indicated the medication was to be given prior to the resident's dental appointment and was not signed off by the nurse. During an interview, on 1/7/25 at 11:53 a.m., the Minimum Data Set (MDS) Coordinator indicated she would need to check why the antibiotic (ATB) was not signed off. The nurse should have signed the medication off on the Medication Administration Record (MAR) when it was given. During an interview, on 1/7/25 at 1:35 p.m., the		physicians orders. Educations will be provided upon hire and annually. DON/designee will audit 5 residents with blood pressure hold orders, antibiotic orders prior to dental visits and orders for sliding scale to ensure physician orders are followed. Audits will occur daily x30 days, then weekly x12 weeks and monthly x5 months. Results of audit will be reported to the Quality Assurance Performance Improvement Committee monthly to assist with additional recommendations if necessary.	

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	Clinical Support Nurse indicated the medication was not signed off on the MAR. The nurse should have signed the medication off in the MAR after giving the medication. There was no way to prove the ATB was given prior to going to the appointment. 3. The clinical record for Resident 52 was reviewed on 1/6/25 at 9:48 a.m. The diagnoses included, but were not limited to, type 2 diabetes without complications, type 2 diabetes mellitus with ketoacidosis (high levels of ketones cause the blood to become more acidic) without coma, and dementia. A physician's order, initiated on 7/21/24, indicated to check the resident blood sugar before meals and at bedtime and to notify the physician if the blood sugar was less than 60 or greater than 400. A physician's order, initiated on 7/21/24, indicated to check the resident's blood sugar prn (as needed) for symptoms of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugars) and to notify the physician if the blood sugar was less than 60 or greater than 400. A physician's order, initiated on 7/21/24, indicated if the blood sugar was less than 60 and the resident could swallow, administer 4 ounces of juice or soda and a short acting carbohydrate. Repeat the blood sugar and notify the physician. A physician's order, initiated on 7/21/24, indicated to give Humalog insulin per the following sliding scale: If the blood sugar was 150 to 190, give 3 units. If the blood sugar was 191 to 230, give 6 units. If the blood sugar was 231 to 270, give 9 units. If the blood sugar was 271 to 310, give 12 units. If the blood sugar was 311 to 350, give 15 units. If the blood sugar was greater than 350, call the			

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	physician. A physician's order, initiated on 11/13/24, indicated to give Humalog Insulin 8 units daily at 12:00 p.m. The resident had a documented high blood sugar level of 414, on 11/29/24 at 11:08 a.m. The Medication/Treatment (MAR/TAR) record indicated the physician was notified. There was no progress note found to indicate the physician had given additional orders to treat the high blood sugar. The resident was given the scheduled 8 units at 12:00 p.m. Per the MAR/TAR, zero (0) units of the sliding scale were given for the resident's high blood sugar. There were no additional orders found for the treatment of the high blood sugar. The resident's blood sugar level was checked on 11/29/24 at 4:00 p.m., and the residents blood sugar was 453. During an interview, on 1/8/25 at 2:12 p.m., the Clinical Support Nurse indicated the documented 0 units for the sliding scale was most likely an error. At this time, any progress notes and any orders which pertained to holding or giving additional insulin were requested. A nursing progress note, dated 12/12/24 at 8:05 a.m., indicated Resident 52 had a blood sugar result of 50. The resident was given two (2) eight-ounce glasses of orange juice and the blood sugar was rechecked 30 minutes later. There was no documentation to indicate the physician had been notified of the low blood sugar. The blood sugar was not documented on the Medication/Treatment record or under the			

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	vital signs. During an interview, on 1/8/25 at 2:33 p.m., RN 8 indicated if a resident was found to have a high or low blood sugar, the staff would notify the physician and follow the orders for the hyper/hypoglycemia protocol. No additional information was provided by the facility. A current facility procedure, titled "Obtaining a Fingerstick Glucose Level," dated as last revised in April 2001 and received from the Corporate Support Nurse on 1/8/25 at 2:12 p.m., indicated "...Follow facility policies and procedures for appropriate nursing interventions regarding blood sugar results...Report abnormal results promptly to the Attending Physician...." A current facility policy, titled "Medication Administration: General Policies and Procedures," not dated and received from the Administrator on 1/7/25 at 12:15 p.m., indicated "...Medications are administered as prescribed in accordance with good nursing principles and practices...All medications are to be administered only as prescribed by a physician...Medication errors...shall be immediately reported to the attending physician, charted in detail in the resident's medical record and described in a full incident report...." A current facility policy, titled "Protocol for Following Physician Orders," dated 4/3/17 and received from the Administrator on 1/6/25 at 10:43 a.m., indicated "...All licensed staff will verify and follow the physician orders as written ...." 3.1-37(a)			

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on interview and record review, the facility failed to ensure catheter urine output was accurately recorded and to document the removal of a urinary catheter with post-removal bladder scan measurements for 2 of 2 residents reviewed for urinary catheters. (Resident 258 and 259) Findings include: 1. The clinical record for Resident 258 was reviewed on 1/3/25 at 11:36 a.m. The diagnoses included, but were not limited to, aphasia following cerebral infarction, memory deficit, stage 3 chronic kidney disease, depression, hypotension, neuromuscular dysfunction of bladder, chronic myeloid leukemia, type 1 diabetes mellitus, and Alzheimer's disease. A physician's order, with a start date of 12/23/24, indicated to empty the Foley catheter every shift and to document the output. A current care plan, with a start date of 12/23/24, indicated to accurately document outputs on the flowsheet every shift. A Treatment Administration Record (TAR), dated 12/23/24 through 1/3/24, indicated to empty the Foley catheter every shift and document the output. On 12/23/24, the night shift had no output recorded. On 12/24/24, the day and evening shifts had "medium" urine outputs recorded. On 12/25/24, the evening shift had medium recorded, and the night shift had large recorded. On 12/26/24, the day and evening shift had large	F 0690	F690 Resident 258 catheter output has been reported to NP with no new orders. Resident 259 no longer resides in the facility. Resident discharged per plan of care. Residents with foley catheters have the potential to be affected by the alleged deficient practice and have been audited to ensure urine output for the last 30 days has been documented accurately and removal with post-void bladder scan measurements per physician's order. Licensed nurses have been educated regarding following physician's orders for accurately measuring foley catheter output and removal of foley catheter with post-removal bladder scan measurements. Education will be provided upon hire and annually. DON/designee will audit 5 residents with foley catheters to ensure urine output is accurately recorded and there is documentation of the removal of the urinary catheter with post-removal bladder scan measurements per physician's orders. Audits will occur daily x30 days, then weekly x12 weeks and monthly x5 months. Results of audit will be reported to the Quality Assurance Performance	01/26/2025

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	recorded. On 12/27/24, the evening shift had medium recorded. On 12/28/24, the evening shift had medium recorded. On 12/29/24, the evening shift had large recorded. On 12/30/24, the evening shift had medium recorded. On 12/31/24, the day shift had large recorded, and the evening shift had medium recorded. On 1/3/25, the day shift had none recorded, the evening shift had small recorded, and the night shift had small/150ml recorded. During an interview, on 1/7/25 at 12:06 p.m., RN 7 indicated she did not know why the exact urine amount was not documented when the CNAs (certified nursing assistant) were emptying the catheter in a graduated cylinder. They should not have been using small, medium, and large for the urine output amounts. During an interview, on 1/7/25 at 3:00 p.m., the Director of Nursing (DON) indicated if there was an order to document outputs then it should have been the actual amount which was charted. 2. The clinical record for Resident 259 was reviewed on 1/7/25 at 11:32 a.m. The diagnoses included, but were not limited to, urinary tract infection and retention of urine. A care plan, with a start date of 12/19/24, indicated to accurately document intakes and outputs. A care plan, with a start date of 1/1/25, indicated the resident had an indwelling urinary catheter. A nurse practitioner's progress note, dated 12/23/24, indicated the resident had significant		Improvement Committee monthly to assist with additional recommendations if necessary.	

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	post void residuals and urology had placed the Foley catheter while the resident was in the hospital. The plan was to order a voiding trial on Friday, 12/27/24. A physician's order, dated 12/20/24 and discontinued 12/29/24, indicated to obtain the Foley catheter output every shift. A physician's order, dated 12/27/24 and discontinued 12/30/24, indicated to remove the Foley catheter and complete a bladder scan every 8 hours. A TAR, dated 12/20/24 through 1/8/25, indicated to record the Foley catheter output every shift: On 12/21/24, there was no Foley catheter output for the day or evening shifts. On 12/27/24, there was no Foley output for the day or night shift. A note for the night shift indicated "not administered due to item not being present." A TAR, dated 12/20/24 through 1/8/25, indicated to remove the Foley catheter and complete a bladder scan every 8 hours. On 12/27/24, "no treatment" was recorded for the day or evening shift, and "small" was recorded for the night shift. The comments for "no treatment" on the day and evening shift were "other." On 12/28/24, "no treatment" was recorded for the night shift with the comment "Foley removed." On 12/29/24, "no treatment" was recorded for the day shift. During an interview, on 1/7/25 at 2:41 p.m., the DON indicated staff should document the amount of urine in milliliters when there was a physician's order to document output. When staff discontinued a catheter, there should be a note in			

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	the progress notes. She was unable to find a note regarding the removal of the catheter except for the notes in the MAR which indicated the catheter was not present or had been discontinued. The notes were confusing with some shifts saying the catheter was present after a previous shift appeared to indicate it was discontinued. The DON indicated she thought the catheter was removed some time on 12/27/24. There were missing bladder scan recordings but without knowing exactly when the catheter was removed, she could not determine exactly how many. A current skills validation procedure, titled "Measuring and Recording Intake and Output Skills Validations," and received from the DON on 1/7/25 at 3:00 p.m., indicated "...Resident's with Foley Catheters are emptied every shift...The bag should be emptied per protocol into either a graduated drainage cup or urinal...After the fluid is gathered, the container should be held at eye level to view the level of the fluid and the amount obtained should be recorded for later documentation into the resident's permanent medical record...Document...source of...output and volumes...." 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview and record review, the facility failed to ensure oxygen equipment was turned on and the physician's orders were followed for 1 of 3 residents reviewed for respiratory care. (Resident 66) Finding includes:	F 0695	F695 Resident 66 no longer resides in the facility. Residents with orders for oxygen have the potential to be affected by the alleged deficient practice and have been audited to ensure	01/26/2025

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	During an observation, on 1/2/25 at 11:21 a.m., Resident 66 was sitting in her recliner wearing oxygen tubing. The resident was having a hard time breathing and was not getting supplemental oxygen. The oxygen concentrator (a device used to provide supplemental oxygen therapy) was not turned on. During an observation, on 1/2/25 at 11:23 a.m., LPN 3 entered the room and checked the oxygen concentrator. The nurse turned on the concentrator and left the room to get the vitals machine to check the resident oxygen saturation. The nurse attached the pulse oximeter to the resident's finger and the resident's saturation was 82%. During an observation, on 1/2/25 at 12:51 p.m., Resident 66's door was closed, and a high-pitched whistling noise was heard coming from the resident's room. The oxygen concentrator had a red light on the top of the machine, the humidity bottle was not bubbling, and the concentrator was making a high-pitched sound. The nurse entered the room and indicated the concentrator was not working. The Minimum Data Set (MDS) Coordinator entered the room to assist the nurse. A new concentrator was brought into the room and the resident's oxygen tubing was attached. The nurse turned the oxygen on 2.5 L (liter/min). The nurse took the resident's oxygen saturation, and it was 82%. During an observation, on 1/2/25 at 12:55 p.m., the MDS Coordinator indicated the physician's order was for continuous oxygen at 3L via nasal canula. The oxygen concentrator was switched to 3L. The clinical record for Resident 66 was reviewed		oxygen equipment is turned on and physician's orders are followed. Associates were educated regarding measures to ensure oxygen equipment is turned on and physician orders are followed. Education will occur upon hire and annually. DON/designee will audit 5 residents with oxygen to ensure oxygen is turned on and physician's orders are followed. Audits will occur daily x30 days, then weekly x12 weeks and monthly x5 months. Results of audit will be reported to the Quality Assurance Performance Improvement Committee monthly to assist with additional recommendations if necessary.	

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	on 1/3/25 at 9:24 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), pneumonia, and heart failure. A care plan, dated as revised 12/5/24, indicated the resident was on oxygen therapy. Interventions included, but were not limited to, administer oxygen as ordered and monitor lung sounds. A physician's order, dated 2/20/23 and discontinued on 1/3/25, indicated continuous oxygen at 3L. A physician's order, dated 1/3/25, indicated may titrate oxygen (0-4 liter/min) to maintain oxygen saturation greater than 88%. During an interview, on 1/2/25 at 11:30 a.m., LPN 3 indicated the resident was on 3L and needed the oxygen to assist with her breathing. The resident had returned from a physician's appointment. LPN 3 was not aware of the time she returned or how long the resident was without oxygen. The resident had COPD and needed the oxygen to help her breath. When the concentrator was turned off, the resident was not receiving any supplemental oxygen and the resident's oxygen level was low. During an interview, on 1/2/25 at 12:51 p.m., LPN 3 indicated she could not hear the concentrator making high pitch sounds when sitting at nurses' station. She thought the concentrator had stopped working. During an interview, on 1/2/25 at 12:53 p.m., the MDS Coordinator indicated the oxygen concentrator was set on 2.5L and the machine was increased to the physician ordered amount.			

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	A current policy, titled "Protocol for Following Physician Orders," dated 4/3/17 and received from the Administrator on 1/6/25 at 10:43 a.m., indicated "...All licensed staff will verify and follow the physician orders as written. If for any reason, the physician order cannot be followed, the licensed professional will contact the physician for further instructions...The resident's plan of care will reflect the physicians order and direction for the resident's plan of care...Upon discontinuation of the physician's order, the resident's plan of care will be updated to reflect the new resident orders...." A current policy, titled "Oxygen Administration," dated 3/2004 and received from the Clinical Support Nurse on 1/8/25 at 2:10 p.m., indicated "...Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration...Assemble the equipment and supplies as needed...Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute...Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated...Periodically re-check water level in humidifying jar...." 3.1-47(a)(6)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to ensure insulin was labeled with an open date, to lock a medication cart before staff walked away, and to store antifungal nail solution separately from eye drops for 2 of 4 medication carts. (Ambassador Square and Heritage Court)	F 0761	F761 Medication carts on Ambassador and Heritage Court were audited during the survey to ensure insulin pens were labelled with date open, locks are engaged when staff walk away and medications of different	01/26/2025

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	155841	A. BUILDING 00 B. WING	01/08/2025

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	Finding includes: 1. During an observation, on 1/7/25 at 7:51 a.m., a Lantus insulin pen was found for Resident 353. The pen had been previously opened and did not have an open date. During an interview, on 1/7/25 at 7:51 a.m., RN 9 indicated the insulin pen had been used prior and did not have an open date. 2. During a random observation, on 1/3/25 at 3:15 p.m., the Ambassador Square unit medication cart 1 was found unlocked. There were two dietary staff in the dining room with a wall obscuring the view of the cart. The nurse was found at the opposite end of the unit. The medication cart could not be observed from her position. During an interview, on 1/3/25 at 3:19 p.m., RN 10 indicated the cart was to be locked before walking away. 3. During an observation of medication storage, on 1/7/25 at 4:27 p.m., Jublia (an antifungal) topical nail solution was found stored with eye drops in the top drawer of medication cart 2 on the Heritage Court unit. During an interview, on 1/7/24 at 4:32 p.m., QMA 2 indicated the items should not have been stored together. A current facility policy, titled "MEDICATION LABELING," provided by the Director of Nursing on 1/2/25 at 3:10 p.m., did not address putting open dates on medications. A current facility policy, titled "DRUG		routes of administration are stored separately. Residents residing on Ambassador and Heritage Court have the potential to be affected by the alleged deficient practice and have been audited to ensure no adverse effects were noted. Licensed nurses and QMAs were educated regarding the medication storage policy. Education will occur upon hire and annually. DON/designee will audit medications carts to ensure insulin pens are labelled with the date opened, medication carts are locked when unattended and medications with different routes of administration are stored separately. Audits will occur daily x30 days, then weekly x12 weeks and monthly x5 months. Results of audit will be reported to the Quality Assurance Performance Improvement Committee monthly to assist with additional recommendations if necessary.	

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	STORAGE," undated and received from the Corporate Support Nurse on 1/8/25 at 2:16 p.m., indicated "...Medication...carts...are locked or attended by persons with authorized access. 3.1-25(k)(6) 3.1-25(m)			
F 9999 Bldg. 00	(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following:	F 9999	F9999 RN 4, C NA 5 and RN 6 have completed 3 hours of dementia training per the state rule. Residents residing in the facility have the potential to be affected by the alleged deficient practice and have audited to ensure there were no adverse effects. An audit was completed to ensure associates have annual dementia training per the state rule. Associates were educated regarding the state rule for 3 hours of annual dementia training. Associates will be educated upon hire and annually. Administrator/designee will audit 5 employee files to ensure 3 hours of annual dementia training is completed. Audits will occur weekly x12 weeks and monthly x6 months. Results of audit will be reported to the Quality Assurance Performance Improvement Committee monthly to assist with additional recommendations if necessary.	01/26/2025

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	(A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure staff had completed three (3) hours of annual dementia training for 3 of 10 staff members reviewed for dementia training. (RN 4, CNA 5 and RN 6) Finding includes: The staffing employee records were reviewed on 1/6/25 at 10:15 a.m. The following staff's dementia training was reviewed: 1. RN 4 was hired on 4/16/14. The employee record did not contain annual dementia training. 2. CNA 5 was hired on 9/27/18. The employee record did not contain annual dementia training. 3. RN 6 was hired on 6/29/16. The employee record did not contain annual dementia training. During an interview, on 1/6/25 at 1:25 p.m., the Administrator indicated she had over 200 staff to monitor. RN 4, CNA 5 and RN 6 did not have the three (3) hours of continued dementia training. The facility would need to make sure the staff received the annual dementia training required. The facility did not have a policy on dementia training.			

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Complaint IN00449971. Complaint IN00449971 - No deficiencies related to the allegations are cited. Survey dates: January 2, 3, 6, 7 and 8, 2025. Facility number: 013556 Residential Census: 65 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on January 14, 2025.	R 0000	**This plan of correction is to serve as CopperTrace Health and Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Copper 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 and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **CopperTrace Health and Living is respectfully requesting that Paper Compliance be considered for this Plan of Correction.**	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure service plans were signed and dated by the resident or the resident's representative for 5 of 7 residents reviewed for service plan agreements. (Resident 2, 3, 5, 6 and 7) Finding includes: 1. The clinical record for Resident 2 was reviewed on 1/3/25 at 12:00 p.m. The diagnoses included, but were not limited to, hyperlipidemia (high	R 0217	R217 Residents 2,3,6, and 7 service plans have been signed and dated by the resident or resident's representative. Resident 5 no longer resides at the facility. Residents residing in the Assisted Living have the potential to be affected by the alleged deficient practice and have been audited to	01/26/2025

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	cholesterol), disorientation, and pain. The facility was unable to provide a signed service plan for the 2024 year. 2. The clinical record for Resident 3 was reviewed on 1/3/25 at 11:38 a.m. The diagnoses included, but were not limited to, aftercare following joint replacement of left hip, pain, and Covid acute respiratory disease. The facility was unable to provide a signed service plan. 3. The clinical record for Resident 5 was reviewed on 1/2/25 at 2:54 p.m. The diagnoses included, but were not limited to psychosis, anxiety, and vitamin deficiency. The facility was unable to provide a signed service plan. During an interview, on 1/2/25 at 3:07 p.m., the Director of Nursing indicated the facility was not able to locate a signed service plan. 4. The clinical record for Resident 6 was reviewed on 1/2/25 at 1:02 p.m. The diagnoses included, but were not limited to, acute kidney failure, cough, and edema. The facility was unable to provide a signed service plan. During an interview, on 1/2/25 at 3:07 p.m., the Director of Nursing indicated a signed service plan could not be located. 5. The clinical record for Resident 7 was reviewed on 1/2/25. The diagnoses included, but were not		ensure service plans have been signed and dated by the resident or the resident's representative. Assisted Living Unit Manager has been educated regarding service plans being signed and dated by the residents or the resident's representative. The DON/designee will audit 5 residents to ensure service plans have been signed and dated by the resident or the resident's representative. Audits will occur weekly x12 weeks and monthly x6 months. Results of audit will be reported to the Quality Assurance Performance Improvement Committee monthly to assist with additional recommendations if necessary.	

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	limited to, hypertension, dementia, and Parkinson's disease. A service plan signature sheet indicated the service plan was reviewed on 11/9/24 but was not signed until 1/2/25. During an interview, on 1/2/25 at 3:30 p.m., the Director of Nursing indicated the service plan should have been signed prior to 1/2/25. A current facility policy, titled "Service Plan," dated as revised in May 2012 and received from the Administrator on 1/6/25 at 10:43 a.m., indicated "...The service plan shall be signed and dated by the resident...."			
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on interview and record review, the facility failed to ensure annual health statements were completed and signed by the physician at least annually for 2 of 7 residents reviewed for annual health statements. (Resident 6 and 7) Finding includes: 1. The clinical record for Resident 6 was reviewed on 1/2/25 at 1:02 p.m. The diagnoses included, but were not limited to, acute kidney failure, cough, and edema. The annual health statement was not found in the resident's medical record. The facility was unable to provide an annual health statement completed prior to the requested date of 1/2/25.	R 0409	R409 The health statements for Residents 6 and 7 have been completed and signed by the physician. Residents residing in Assisted Living have the potential to be affected by the alleged deficient practice and have been audited to ensure the annual health statements have been completed and signed by the physician. Licensed nurses were educated to ensure the annual health statements are completed and signed by the physician. Education will occur upon hire and annually. The DON/designee will audit 5 residents to ensure the annual	01/26/2025

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	During an interview, on 1/2/25 at 3:07 p.m., the Director of Nursing indicated orders were placed 1/2/25 and were waiting for the physician's signature. The facility did not currently have an annual health statement prior to 1/2/25. 2. The clinical record for Resident 7 was reviewed on 1/2/25. The diagnoses included, but were not limited to, hypertension, dementia, and Parkinson's disease. The annual health statement was not found in the record. During an interview, on 1/2/25 at 3:07 p.m., the Director of Nursing indicated orders were placed 1/2/25 and were waiting for the physician's signature. The facility did not have an annual health statement for the resident. A current facility policy, titled "Procedure: Health Services," dated as last revised in May 2012 and received from the Administrator on 1/8/25 at 10:48 a.m., indicated "...a statement that the resident shows no evidence of tuberculosis, no evidence of an infectious stage, and will be verified on admission and yearly thereafter...."		health statement has been completed and signed by the physician. Audits will occur weekly x12 weeks and monthly x6 months. Results of audit will be reported to the Quality Assurance Performance Improvement Committee monthly to assist with additional recommendations if necessary.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on interview and record review, the facility failed to ensure a two-step Mantoux (tuberculosis screening) test was completed timely for 1 of 7 residents reviewed for tuberculosis testing upon admission to the facility. (Resident 4) Finding includes: The clinical record for Resident 4 was reviewed on	R 0410	F410 Resident 4 no longer resides at the facility. Residents residing in Assisted Living have the potential to be affected by the alleged deficient practice and have been audited to ensure they have received the two step Mantoux.	01/26/2025

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	1/2/25. The diagnoses included, but were not limited to, type 2 diabetes, hypokalemia (low potassium level), and diastolic heart failure. A facility document, titled "Preventive Health Care," undated and received from the Director of Nursing on 1/3/25 at 1:54 p.m., indicated the first test was completed on 3/8/24 and a follow up Mantoux test was not completed until 6/21/24. During an interview, on 1/3/25 at 1:54 p.m., the Director of Nursing indicated the two-step test had not been completed. "Clinical Testing Guidance for Tuberculosis: Tuberculin Skin Test" (May 14, 2024) was retrieved on 1/9/25 from the Centers of Disease Control (CDC) website. The guidance indicated "...If the first TB skin test result is negative, a second TB skin test should be done 1 to 3 weeks later...." A current facility policy, titled "Policy: Mantoux Testing Policy," dated as last revised in May 2012 and received from the Administrator on 1/6/25 at 10:43 a.m., indicated "...All assisted living residents will have a two-step Mantoux upon admission...." A current facility policy, titled "Procedure: Health Services," dated as last revised in May 2012 and received from the Administrator on 1/8/25 at 10:48 a.m., indicated "...Residents will be given a two-step Mantoux test upon admission...."		Licensed nurses have been educated to ensure the two step Mantoux is initiated upon admission. Education will occur upon hire and annually. The DON/designee will audit 5 residents to ensure the two step Mantoux has been completed. Audits will occur weekly x12 weeks and monthly x6 months. Results of audit will be reported to the Quality Assurance Performance Improvement Committee monthly to assist with additional recommendations if necessary.	