STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155841	A. BUILDING -- B. WING	02/03/2025

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/03/25 Facility Number: 013556 Provider Number: 155841 AIM Number: 201341880 At this Emergency Preparedness survey, Copper Trace Health & 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 97. Quality Review completed on 02/05/25	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: 02/03/25 Facility Number: 013556 Provider Number: 155841 AIM Number: 201341880 At this Life Safety Code survey, Copper Trace	K 0000	February 14, 2025 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: 0OOC21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy Pollock	Administrator	02/14/2025

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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	Health & 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. 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 corridor and has hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 104 and had a census of 97 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached storage building. Quality Review completed on 02/05/25		Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on February 3, 2025. This letter is to inform you that the plan of correction attached is to serve as CopperTrace Health & Living Community credible allegation of compliance. We allege substantial compliance on February 14, 2025. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-844-5050 Sincerely, Nancy Pollick, HFA Administrator Copper Trace Health and Living Submission of this plan of correction in no way constitutes an admission by Copper Trace Health and Living 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	

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			this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the	K 0324	**K 324** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that there is an appropriate method to ensure that kitchen equipment gets returned to the approved location when removed for repair or cleaning. The Maintenance Supervisor has marked the floor to show exact placement and has created a diagram showing the proper location. This diagram will be hung in the dietary manager's office. See attached picture showing the floor marked for proper equipment placement. **II. The facility will identify**	02/14/2025

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	appliance is returned to an approved design location. The deficient practice could affect as many as 32 residents, 6 staff, and 2 visitors in the facility. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 02/03/25 at 12:15 p.m., the four (4) burner stove and the flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and/or cleaning. Based on interview at the time of the observation, the Maintenance Director stated that he was not aware an approved method should be provided to ensure that the appliance is returned to an approved design location after maintenance or cleaning and that he would have something done to the kitchen stove or floor to meet code compliance as soon as he could. This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 02/03/25. 3.1-19(b)		**other residents that may potentially be affected by the deficient practice.** All residents and staff could have been affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Maintenance Supervisor has a new monthly TELS task to inspect the kitchen equipment placement to ensure they are all located in the proper position. See attached task labeled "Kitchen Equipment Placement TELS Task" **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect the kitchen equipment placement during their annual CQR to ensure each piece of equipment is in their proper location.	
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical	K 0911	**K 911** **I. The corrective actions to be**	02/14/2025

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	apparatus in 1 of 4 utility rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect as many as 18 residents, 4 staff, and 2 visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility on 02/03/25 at 11:54 a.m., there was a 12-foot ladder and a cardboard box full of miscellaneous items in the utility room located in the common area. This utility room contained five wall mounted electric panels. The aforementioned ladder and box were stored within the working space for the five-wall mounted electrical panels and would make accessing them difficult in the event of an emergency. Based on interview at the time of the observations, the Maintenance Director agreed items were stored within the working space in front of the electrical panels in the utility room. This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 02/03/25. 3.1-19(b)		**accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that the electrical switch gear, in the main electrical room, was free and clear of items blocking them. There was a 12 ft ladder and box of electrical devices blocking the front of the electrical panel. The Maintenance supervisor has relocated those items so they do not block the electrical switch gear. See picture showing these items removed. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current Monthly TELS task to inspect all electrical and mechanical rooms to ensure nothing is blocking the electrical panels. See attached TELS task label “Copper Trace Electrical Room TELS Task”	

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			IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities will inspect all electrical and mechanical rooms during their site visits to ensure nothing is blocking the electrical switch gears or panels.	