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	07/24/2023

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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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00412733. Complaint IN00412733 - Federal/State deficiencies related to the allegations are cited at F561. Survey dates: July 21 and 24, 2023 Facility number: 013556 Provider number: 155841 AIM number: 201341880 Census bed type: SNF: 26 SNF/NF: 78 Residential: 35 Total: 139 Census payor type: Medicare: 8 Medicaid: 56 Other: 40 Total: 104 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed August 2, 2023.	F 0000	**Copper Trace Health and Living respectfully requests Paper Compliance in relation to this Plan of Correction. This plan of correction is to serve as Copper Trace 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.**	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of			

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

Nancy Pollock | Administrator | 08/07/2023

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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	this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review, the facility failed to ensure a resident and her representative's choice of caregiver was consistent with her plan of care for 1 of 3 residents reviewed for choices. (Resident B) Finding includes: A document, titled "Indiana State Department of Health Survey Report System," undated and provided by the ED (Executive Director) indicated on July 10, 2023, a family member reported a concern with the provision of care given to Resident B by a male caregiver. A sexual trauma examination was completed with no findings. The family sought alternate placement for the resident	F 0561	**F561 Self-Determination CFR(s): 483.10(f)(1)-(3)(8)** **Residents B is discharged from the facility.** **Residents who prefer male caregivers have the potential to be affected by the alleged deficient practice. The plan of care has been audited for residents who have voiced a specific preference related to caregivers to ensure consistency with that stated preference.** **Education has been provided**	08/11/2023

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	and the transfer was facilitated on 7/12/23. The record for Resident B was reviewed on 7/21/23 at 12:38 p.m. Diagnoses included, but were not limited to, vascular dementia with mild psychotic disturbance, anxiety disorder, hallucinations, attention and concentration deficit, cerebral infarction, and restlessness and agitation. An email, addressed to the ADON (Assistant Director of Nursing), UM, ED and Hospice Nurse on 6/21/23 at 4:50 p.m., indicated Resident B's daughter spoke to the ADON regarding her mother's fears about the "disgraceful man" she described and feared was touching her behind her brief. The ADON's intervention was to have only female caregivers for her mother and that was a "reasonable" intervention for the daughter. The progress notes were reviewed, which included, but were not limited to, the following notes: On 6/21/2023 at 5:13 p.m., the writer had a conversation with the resident's daughter that afternoon regarding her concerns and fears. Resident B indicated men came through her window with three trees they had chopped down, then began making breakfast burritos in her room. They threw her house coat on the floor, indicating to a place on the floor, they scared her and touched her inappropriately. There was no clothing observed on the floor at that time. The window was closed and locked. The daughter indicated she believed the resident was having increased delusions. Adjustments were made to the residents ADL care plan, which her daughter was in agreement with. On 7/11/23 at 10:19 p.m., Resident B's daughter		**to nursing staff on self-determination. The systemic change includes education for nursing staff upon hire and annually.** **The Director of Nursing/Designee will audit consistency of honoring caregiver preferences. This audit will occur on five (5) residents who have voiced a preference per week for 30 days, then five (5) residents who have voiced a preference per month for 11 months to total 12 months of monitoring.** **Results of this audit will be reported to the Quality Assurance Performance Improvement Committee monthly to assist with additional recommendations if necessary.**	

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	requested she be sent to the ER (Emergency Room) for further examination. Police called EMS (Emergency Medical Services) and gave hospital report. The resident was sent to hospital by ambulance. On 7/11/23 at 9:35 p.m., Resident B arrived back to her room by stretcher and ambulance. She was alert and oriented to self with incoherent speech. On 7/12/23 at 8:31 a.m., Social Services (SS) was notified Resident B's daughter was interested in transferring her to an alternate facility. On 7/12/23 at 8:39 a.m., Resident B was at the dining room table eating. She took a bite of food, then fell asleep and was hard to arouse. The food was removed from her mouth, and she would not take her medications. When the daughter was notified, she indicated her mother had a rough and invasive day the day before and she was probably tired. The nurse agreed and had the CNA lay the resident back in bed to rest. On 7/12/23 at 10:50 a.m., SS spoke with Resident B's daughter regarding scheduling a care plan meeting. The daughter declined the care plan meeting and indicated she wanted to discuss a discharge planning meeting between herself, and SS. SS started the discharge process to the facility of the daughter's choosing. On 7/12/23, a Nurse Practitioner's note indicated Resident B was being seen that day following a recent trip to the ER on 7/11/23, as requested by her daughter due to an accusation of sexual assault. She returned to the facility on 7/11/23 and was observed to have speech incoherent nests (unintelligible words). She was discharged to another facility on 7/13/23.			

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	On 7/12/23 at 4:51 p.m., Resident B was transferred to the alternate facility. Resident B's care plans were reviewed, which included, but were not limited to, the following: The resident had a care plan, which addressed she and her responsible party preferred female caregivers to provide ADL care (dated 6/21/23). The approaches included, but were not limited to, 6/21/23, female caregiver to provide incontinence care with toileting as needed, and 6/21/23, female caregivers to assist/encourage resident in proper transfer bed mobility, toileting/hygiene and eating techniques as needed. The resident had a care plan which addressed the problem she had a history of experiencing past trauma for example, negative interactions with caregivers and history of allegation of "abuse" at a previous LTC (long term care) facility prior to admitting to this facility (dated 2/14/23). The goal was Resident B would show minimal signs/symptoms of negative psychosocial wellbeing related to experience of past trauma. The resident had a care plan, which addressed the problem she had a history of hallucinations, delusions, and paranoia. She had a history of seeing persons/objects not present, becoming fixated on items, history of exhibiting beliefs that negative life events would occur because she prays, believed someone was speaking negatively about her, persons/little boy was outside her window attempting to harm her and she would exhibit hallucinations and delusions that persons and animals were in front of her and telling her she was able to walk (dated 2/9/23).			

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	The resident had a care plan, which addressed the problem she had a diagnosis of anxiety disorder and had a history of symptoms of anxiety, anxiousness, restlessness, excessive worry, and paranoia were her most common symptoms. Resident B's quarterly MDS (Minimum Data Set) assessment, dated 2/7/23, indicated her preference to have her family involved in discussions about her care was very important to her. Her functional status indicated she required extensive assist with two-person physical assist for these ADL's: bed mobility, transfer, and toileting. A current as worked schedule, dated July 9, 2023, indicated LPN 1 and CNA 2 was on the schedule and worked on the 500 unit the night shift of July 9,2023 going into the early morning of July 10, 2023, which was the unit Resident B lived on. During an interview, on 7/21/23 at 11:51 a.m., the Unit Manager for the 500 unit indicated Resident B was not to have any male care givers providing intimate care to her, but a male care giver could be in her room as the second person to help turn and reposition her or get her out of the bed with the Hoyer lift. The no male care giver started back at the end of June when Resident B thought a man with a green face came through her window and touched her inappropriately. As the intervention, the facility told her daughter and her there would be no male caregivers providing care for her, but that meant intimate care, not going in her room to help turn her or get her up with a female caregiver. During an interview, on 7/21/23 at 2:25 p.m., CNA 2 indicated on the nightshift of 7/9/23, he worked on the opposite hallway, which Resident B lived on. Between 3 and 4 a.m., LPN 1 asked him to assist her with Resident B, so he did. The nurse			

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	had already given the peri care and all he did was assist the resident with turning, so she could get her bed linens changed. He knew over the past month no men were to be taking care of her, so he did not give her peri care. He did go into that room during the night and assist her roommate to the bathroom, but he did not touch Resident B any of those times. During a phone interview, on 7/24/23 at 12:39 p.m., Resident B's daughter indicated when she talked with the ADON (Assistant Director of Nursing) on 6/21/23, she had told them Resident B's preference for caregivers was female only. She was told by the ADON there would be no male caregivers in her mother's room. She was told after the 7/10/23 incident, by the ED, there had been a male caregiver in the facility, but he had not been in her mother's room, even though there was one scheduled for her unit on the night shift of 7/9/23. She asked why the facility would allow a male caregiver to go into her room even with a female caregiver and place her mother in the position they placed her and placed an innocent male caregiver in the position they placed him in, on the morning of 7/10/23. She had a concern the facility would continue to allow the male caregiver to enter Resident B's room, so she transferred her to an alternate facility even though she knew transferring her might cause her health and cognitive function to decline further. This Federal tag relates to Complaint IN00412733. 3.1-3(t)			