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	09/14/2022

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. Survey dates: September 7, 8, 9, 12, 13 and 14, 2022 Facility number: 013556 Provider number: 155841 AIM number: 201341880 Census Bed Type: SNF/NF: 77 SNF: 21 Residential: 36 Total: 134 Census Payor Type: Medicare: 16 Medicaid: 60 Other: 22 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on September 26, 2022.	F 0000	**Copper Trace Health and Living requests paper compliance for the following deficiencies. 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 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment was coded correctly to indicate a	F 0641	MDS discharge for Resident #87 was corrected during the survey.	10/14/2022

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

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	09/14/2022

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
	resident's correct discharge status for 1 of 3 closed records reviewed for discharge (Resident 87). Finding includes: On 9/14/22 at 10:06 a.m., Resident 87's closed medical record was reviewed for "hospitalization." The progress notes, dated 7/06/22 at 3:15 p.m., indicated Resident 87 had discharged back to her assisted living facility, following a rehabilitation stay, from 6/17/22 to 7/6/22. A review of the discharge MDS assessment, dated 7/6/22, indicated Resident 87 was discharged to an acute hospital and return was not anticipated. During an interview, on 9/14/22 at 10:24 a.m., the Director of Nursing (DON) indicated the MDS assessment was coded wrong. There was no policy, they followed the Resident Assessment Instrument (RAI) manual for coding of the MDS assessments. During a review of CMS's (Centers of Medicare and Medicaid) RAI (Resident Assessment Instrument) Version 3.0 Manual, on 3/26/18, it indicated "...Residents should be the primary source of information for resident assessment items..." and instructions for discharge information "...Review the medical record including the discharge plan and discharge orders for documentation of discharge location...." 3.1-31(i)		Residents who discharge from the community have the potential to be affected by the alleged deficient practice. Residents who have discharged within the past 30 days have been audited for MDS accuracy. Education will be provided to MDS associates using the MDS manual. The systematic change will include education of MDS associates upon hire and annually. DON/designee will audit 5 residents discharge MDS to ensure accuracy is being maintained. Audits will occur daily x 30 days, weekly x12 weeks and monthly x5 months for a total of 9 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	
F 0656 SS=D	483.21(b)(1) Develop/Implement Comprehensive Care Plan			

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	09/14/2022

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
Bldg. 00	§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive			

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	09/14/2022

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
	care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, interview and record review, the facility failed to develop person centered care plans for 1 of 20 residents reviewed for care plans (Resident 286). Finding includes: On 9/9/22 at 10:09 a.m., during a random observation on the Cherished Memories, memory care unit, Resident 286 was observed in a wheel chair with her right arm in a sling. An unidentified staff member was wheeling her in the hall. The resident was alert and calling out "Help me help me." On 9/9/22 at 2:22 p.m., the medical record was reviewed for Resident 286. The diagnoses included, but were not limited to, fracture of the upper right humorous (arm), altered mental status and anxiety. Resident 286 had multiple care plans in place. A care plan, dated 9/1/22, indicated Resident experienced bladder incontinence related to "_____." The section was blank with no indication. Another care plan, dated 9/1/22, indicated "Resident has ____(impaired, moderately impaired, slightly impaired, or severely impaired) vision R/T [related to] _____." The blanks were not completed, choices were offered. A care plan dated 9/1/22, indicated "Resident requires ____ assistance with oral hygiene r/t _____. " Blanks were not filled in with a response.	F 0656	Care Plans for resident #286 was updated with patient centered content during the survey. Residents residing in the community have the potential to be affected by the alleged deficient practice and have been audited to ensure their care plans are person centered. Education will be provided to MDS associates regarding person centered care plans. Systemic change will include education to MDS associates upon hire and annually. DON/designee will audit 5 newly admitted residents care plans to ensue they contain person centered information. Audits will occur daily x 30 days, weekly x12 weeks and monthly x5 months for a total of 9 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	10/14/2022

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	09/14/2022

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
	Another care plan, dated 9/1/22, indicated "Resident is at risk for adverse consequences R/T receiving antianxiety medication for treatment of _____(reason for medication)." The blank area was not completed with a response. During an interview, on 9/13/22 at 10:48 a.m., the Director of Nursing indicated they used care plan templates and all the information, specific to the resident should have been filled in to make it resident specific. A current policy, titled "Care Plans-Comprehensive," dated October 2009 and provided by the Executive Director (ED) on 9/13/22 at 10:25 a.m., indicated "...An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs is developed for each resident...." 3.1-35(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to			

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	09/14/2022

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
	promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to monitor and prevent a Stage III pressure ulcer development for 1 of 3 residents reviewed for pressure (Resident 6). Finding includes: On 9/12/22 at 10:33 a.m., the medical record was reviewed for Resident 6. The diagnoses included, but were not limited to Stage III pressure ulcer of the left heel, altered mental status, Alzheimer's Disease and edema. A nurse progress note, dated 7/8/22 at 3:15 p.m., indicated Resident 6 was noted to have a Stage 2 pressure ulcer to left heel. The Wound NP (Nurse Practitioner) was in today and new orders were received for betadine soaked gauze with ABD pad and to wrap with kerlix. Change every day and as needed for soilage/dislodgement. Resident did not have any pain in the area and tolerated the assessment/dressing change well. Edema was noted to the BLE (bilateral lower extremities). The daughter was made aware of all of the above. On 7/8/22 at 3:55 p.m., the Wound Document Management Report, included, but was not limited to the following measurements: length - head to toe centimeters 5. Width- side to side 6.5. Fully reabsorbed blister with dry epidermis remaining. On 7/15/22 at 3:59 p.m., length 3 cm, width 5.4 cm, depth 0.1 cm. On 7/22/22 at 4:00 p.m., length 3.8 cm, width 4.5 cm, depth 0.1 cm. Stage III. On 7/29/22 at 5:22 p.m., length 3.5 cm, width 3.8 cm, depth 0.1 cm., necrotic tissue On 8/5/22 at 4:30 p.m., length 3 cm, width 3.8 cm, depth 0.1 cm, Stage III, necrotic tissue	F 0686	CopperTrace Health and Living is asking for a face-to-face IDR as we do not agree with the findings for this deficiency. Resident #6 has been monitored and received preventative measures in an effort to prevent pressure ulcers including heels up device, pressure reducing mattress and turning and repositioning per plan of care. Residents residing in the community have the potential to be effected by the alleged practices and have been audited to ensure preventative measures are in place to prevent pressure ulcer development. Nursing associates will be educated regarding pressure ulcer prevention. The systemic change includes education to nursing associates upon hire and annually. DON/designee will audit 5 residents at risk for pressure ulcers to ensure that preventative measures are in place. Audits will occur daily x 30 days, weekly x12 weeks and monthly x5 months for a total of 9 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting.	10/14/2022

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	09/14/2022

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
	On 8/26/22 at 1:43 p.m., length 3.5 cm, width 3.5 cm, depth 0.3 cm, wound healing status- declining A nurse progress note, dated 7/29/22 at 1:31 p.m., indicated the Wound NP (Nurse Practitioner) assessed the resident's left heel. The resident's wound had decreased in size. Measurements were 3.5 cm x 3.8 cm x 0.1 cm. 20% granulation tissue, 80% eschar, light serosanguinous tissue. The resident's swelling remained in the lower leg with pitting edema. The NP ordered venous and arterial dopplers. The resident denied pain. No warmth or tenderness was noted. The daughter was made aware of all of the above. Skin assessment sheets were requested for review. The treatment record for Resident 6, from 6/12/22 through 7/12/22 indicated "Weekly head to toe skin inspection to be completed per licensed nurse. If any new areas are noted complete the change of condition event." The document was initialed weekly by nursing staff. There was one skin risk assessment in the observation record since admission, 6/21/22. No other risk assessments, scores were found in the medical record. On 6/21/22 at 2:46 p.m., Skin Risk Assessment, indicated weekly skin risk, unscheduled completed. The assessment did not indicate any skin concerns. All Skin risk/wound care plans were requested. One care plan was provided, dated 7/8/22. "...Resident has Stage 3 pressure ulcer to L heel." The goal, target date 11/17/22, indicated "Pressure ulcer will heel without complications." On 9/12/22 at 11:07 a.m., Resident 6's left heel		Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	

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	09/14/2022

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
	wound dressing change was observed with Registered Nurse (RN) 8 and the Infection Preventionist (IP). RN 8 indicated Resident 6's wound was facility acquired, after admission. The wound had light exudates, pale thin watery discharge, and approximately 33% granulation tissue. No measurements were taken at that time. The wound appeared about the size of a mandarin orange. During an interview, on 9/13/22 at 10:59 a.m., with the Director of Nursing (DON) and RN 8, they indicated the wound was first identified on 7/8/22 by a certified nurse aid (CNA) who had been providing care to the resident. That was a Friday, the nurse practitioner (NP) was informed and saw it on Monday. It was a blister at that time but opened up within a week. It was identified as a Stage III on 7/15/22. Prior to the wound development, the resident had a "heels up" device placed at night to keep the heels off the bed. There was no order for it, it was a nursing measure. The device was on the CNA assignment sheet. The use was not documented on the treatment record (TAR) because there was not a doctor's order, it would have had to have an order to generate a place to document on the TAR. She had some edema (swelling) noted in her legs back on 6/20/22 and they had ordered PRN (as needed) Lasix (a diuretic) for 3 days. They had done an echo cardiogram for the edema but it showed no CHF (Congestive Heart Failure). She was an extensive one person assist to turn and reposition. On 7/30/22, they did doppler studies (for blood flow) and did determine there was some arterial stenosis in the LLE (left lower extremity). The resident wore non-skid socks, the edema was a contributing factor. When she would roll around in bed the heels up device was not effective. The nursing staff did not complete a weekly skin			

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	09/14/2022

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
	assessment form in the observation record unless a problem was identified in the skin assessment. They initialed on the TAR. A current policy, titled "Wound Management Policy," dated 2/1/19 and provided by the Executive Director (ED) on 9/13/22 at 10:25 a.m., indicated "...each wound will be observed by the wound team to provide oversite of the care plan interventions and ensure that the resident's skin condition is accurately assessed in a timely manner...." The policy did not discuss any preventative measures. 3.1-40(a)(1)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a resident with a history of falls who required assistance with activities of daily living (ADLs) received adequate supervision to prevent further accidents. (Resident 146) Finding includes: Resident 146 was observed during the initial tour,	F 0689	CopperTrace Health and Living is asking for a face-to-face IDR as we do not agree with the findings for this deficiency. Resident #146 discharged to home per his plan of care. Residents residing in the community who have a history of	10/14/2022

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	09/14/2022

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
	09/07/2022 at 11:42 a.m., to be sitting in a wheelchair with his wife sitting in a chair in his room. The resident's left arm was wrapped with an ace bandage from above his elbow to halfway down his forearm and his arm was in a sling. During an interview, with the resident at this time, he indicated he fell on the sidewalk at his home prior to admission about a week ago and broke his elbow. His wife stated the resident had "many" previous falls, adding "he's been lucky that he didn't hit his head" during any of his falls. She indicated this was the "most serious" of his falls to date. The record for Resident 146 was reviewed on 09/08/2022 at 4:42 p.m. Diagnoses included, but were not limited to, fracture of left humerus, attention and concentration deficit, weakness, unsteadiness on feet, abnormalities of gait and mobility, hypertension, anxiety disorder, osteoarthritis and PTSD (post-traumatic stress disorder). A progress note, by the NP (nurse practitioner), dated 09/02/2022, indicated the resident was admitted to the hospital emergency room following a fall at home on 08/22/2022. At the time of the fall, he had "let his dog out around 2AM and tripped and fell. Resident's wife stated she found him laying outside at 9:30 in the morning ...resident is here to rehab to home." The resident was admitted to the hospital and required surgery to repair the fracture and then admitted to the facility. A progress note, dated 09/07/2022 at 4:26 p.m., indicated "...Patient yelled out and therapist found resident on floor and alerted staff. Writer found patient sitting on floor in front of wheelchair with phone on floor off the hook. He stated he was		falls and required assistance with ADL's have the potential to be affected by the alleged deficient practice and have been audited to ensure they receive adequate supervision. Education will be provided to nursing associates using the fall prevention policy. The systemic change incudes education to nursing associates upon hire and annually. DON/designee will audit 5 residents who require assistance with ADL's to ensure supervision is received in an effort to prevent falls. Audits will occur daily x 30 days, weekly x12 weeks and monthly x5 months for a total of 9 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	

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	09/14/2022

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
	trying to get back into chair although foot pedals were present...BP (blood pressure) slightly low at 99/65...brought to main area for supervision...." A fall risk assessment, dated 09/01/2022, indicated Resident 143 had lower and upper extremity weakness, was incontinent of bowel and bladder and did not have a history of falls. Resident 146's admission plan of care, dated 09/01/2022, listed a problem of "Safety interventions to minimize the risk of falling or sustain injury during the fall". Interventions listed for this problem, included, but were not limited to, "...patient education of fall prevention such as using the call light for assistance...." "...staff visit resident to anticipate needs more frequently for the first 4 hours...." and "...resident has appropriate footwear in place to prevent sliding...." A current facility policy, titled Fall Prevention Policy and Procedure, undated and received on 09/12/2022 at 12:18 p.m., indicated "...Accurate documentation of fall risks and falls provides a clinical picture of a resident and is utilized in developing their plan of care...fall risk assessment was to be completed on each new admission...." 3.1-45(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

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	09/14/2022

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
	§483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure medications were labeled with an open date and failed to discard a medication in a timely manner after it was opened for 2 of 2 medication refrigerators and 1 of 4 medication carts observed. (600 hall, 700 hall, 500 hall and Medication Cart 1) Findings include: 1. On 9/12/22 at 2:29 p.m., with LPN 10 present, the medication refrigerator on the 600 hall had the following medications without the correct labeling: a. Trulicity (an injectable medication used to treat Diabetes Mellitus) - without an open date. b. Morphine Sulphate (a narcotic used to treat pain) - without an open date.	F 0761	Medications that were not labeled with an open date and/or discarded in a timely manner have been discarded and reordered. Open dates have been updated. Residents residing in the community have the potential to be affected be the alleged deficient practice. Medication carts and medication refrigerators have been audited to ensure medications requiring open dates and discarded in a timely manner after opening are labelled appropriately. Education will be provided to licensed associates regarding medication labeling and storage. The systemic change includes	10/14/2022

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	09/14/2022

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
	During an interview, at that time, LPN 10 indicated the bottles should have been labeled with an open date. 2. On 9/12/22 at 2:51 p.m., with the UM (unit manager) present, the medication refrigerator on the 700 hall had the following medications without the correct labeling: a. Ativan (a medication used to treat anxiety) - had an open date of 5/26/22. The medication instructions on the bottle indicated to discard 90 days after it was opened. During an interview, at that time, the UM indicated she was not aware the medication should have been discarded. 3. On 9/12/22 at 3:28 p.m., with LPN 11 present, Medication Cart 1, on the 500 hall, had the following medications without the correct labeling: a. Morphine Sulphate - without an open date. b. Albuterol Sulphate (a medication inhaled to make breathing easier) - without a resident name or an open date. During an interview, at that time, LPN 11 indicated the medications should have been labeled with an open date and the resident's name. During an interview, on 9/12/22 at 4:04 p.m., the Corporate Support Nurse indicated the Morphine, Trulicity, and Albuterol Sulphate should have been dated when opened, and the Lorazepam bottle should have been discarded as indicated on the bottle. A current policy, undated, titled "Drug Storage,"		education to the licensed associates upon hire and annually. DON/designee will audit 5 medication carts and/or medication refrigerators to ensure medication storage and labeling is maintained. Audits will occur daily x 30 days, weekly x12 weeks and monthly x5 months for a total of 9 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	

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	09/14/2022

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
	provided by the Executive Director on 09/13/22 at 10:29 a.m., indicated "...Medications will be stored at the facility in a manner consistent with Centers for Disease Control recommendations...Discontinued and expired medications should be removed from medication carts, refrigerators...promptly...Insulin and other multi-dose injectable vials or pens must be discarded after 28 days...Insulin and...other multi-dose vial requiring refrigeration need to be dated when opened...." 3.1-25(m)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: September 7, 8, 9, 12, 13 and 14, 2022 Facility number: 013556 Residential Census: 36 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on September 26, 2022.	R 0000	**Copper Trace Health and Living requests paper compliance for the following deficiencies. 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.**	

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	09/14/2022

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
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to obtain a semi-annual evaluation and failed to obtain a self-administration medication evaluation for 3 of 7 resident records reviewed for semi-annual evaluations and self-administration of medications. (Residents 2, 3 and 5) Findings includes: 1. The record for Resident 2 was reviewed on 09/12/2022 at 1:49 p.m. Diagnoses included, but were not limited to, hypertension, stroke and high cholesterol. An admission documentation sheet indicated Resident 2 was admitted to the facility on 03/31/2021. 2. The record for Resident 3 was reviewed on 09/12/2022 at 2:30 p.m. Diagnoses included, but were not limited to, depressive disorder and hypertension.	R 0216	Semi-annual evaluations and self-administration of medication evaluations for Residents #2, #3 and #5 have been completed. Residents residing in the community have the potential to be affected by the alleged deficient practice and have been audited to ensure the semi-annual evaluation and self-administration of medication, when indicated, have been completed. Education will be provided to the Assisted Living nurse manager regarding completing semi-annual evaluations and self-administration of medication evaluations, when indicated. The systemic change includes education upon hire and annually.	10/14/2022

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	09/14/2022

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
	An admission documentation sheet indicated Resident 3 was admitted to the facility on 10/19/2016. 3. The record for Resident 5 was reviewed on 09/13/2022 at 9:40 a.m. Diagnoses included, but were not limited to, hypertension, high cholesterol and pre-diabetes. An admission documentation sheet indicated Resident 5 was admitted to the facility on 06/06/2018. A document, titled "Copper Trace Residential Unit, Residents who self-administer medications," was provided by the Executive Director on 09/12/2022 at 1:00 p.m., and indicated Resident 2, 3, and 5 self-administered their medications. During an interview, on 09/12/2022 at 4:15 p.m., the Director of Nursing indicated he could not provide a semi-annual evaluation or an assessment enabling a resident to self administer medications for Resident 2, 3, and 5 and both documents should have been in the resident's record. During an interview, on 09/13/2022 at 8:54 a.m., the Corporate Support Nurse indicated the facility did not have any policies in place for the Residential Unit and the facility follows all state regulations and guidelines.		DON/designee will audit 5 residents to ensure the semi-annual evaluations and self-administration evaluations, when indicated, are complete. Audits will occur daily x 30 days, weekly x12 weeks and monthly x5 months for a total of 9 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a			

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	09/14/2022

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
	PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure administration of a PRN (as needed) medication was approved by a licensed nurse prior to being administered by a QMA (Qualified Medication Aide) for 1 of 7 records reviewed for PRN medications administered by a QMA. (Resident 1) Finding includes: The record for Resident 1 was reviewed on 09/12/2022 at 2:21 p.m. Diagnoses included, but were not limited to, Parkinson's disease and CHF (congestive heart failure) and anxiety disorder. A physician's order, dated 09/06/2022, indicated the resident could receive 0.5 mg (milligrams) of Ativan (a medication used to treat anxiety) every 4 hours as needed for anxiety. The MAR (medication administration record), dated 09/01/2022 to 09/12/2022, indicated the resident received Ativan 0.5 mg from QMA 13 on 09/11/22. During an interview, on 09/12/2022 at 4:15 p.m., the Director of Nursing indicated QMAs should obtain and document authorization from a licensed nurse prior to giving any PRN medication and he could not provide documentation the QMA had notified a licensed nurse for authorization prior to administering the medication. During an interview, on 09/13/2022 at 8:54 a.m., the	R 0246	Resident #1 has been assessed for and has not had any adverse effects related to the alleged deficient practice. Residents residing in the community have the potential to be affected by the alleged deficient practice and have been audited to ensure an assessment by a licensed nurse was completed prior to receiving PRN medications in the past 30 days. Education will be provided to licensed associates and QMA's regarding assessment of the resident prior to receiving PRN medication. The systemic change will include education upon hire and annually. DON/designee will audit 5 residents with PRN medications to ensure that a licensed nurse performed an assessment prior to administration. Audits will occur daily x 30 days, weekly x12 weeks and monthly x5 months for a total of 9 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if	10/14/2022

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	09/14/2022

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
	Corporate Support Nurse indicated the facility did not have any policies in place for the Residential Unit and the facility follows all state regulations and guidelines.		compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to administer admission 2-step Tuberculin (TB) skin tests (a test used to determine if a person had been exposed to Tuberculosis) for 3 out of 7 records reviewed for TB skin testing. (Resident 1, 4 and 6) Findings include: 1. The record for Resident 1 was reviewed on 09/12/2022 at 2:21 p.m. Diagnoses included, but	R 0410	Residents #1, #4, and #6 have received a two-step TB test. Residents residing in the community have the potential to be affected by the alleged deficient practice and have been audited to ensure they have received a two-step TB test. Education will be provided to the	10/14/2022

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	09/14/2022

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
	were not limited to, Parkinson's disease and CHF (congestive heart failure). An admission documentation sheet indicated Resident 1 was admitted to the facility on 09/06/2022. 2. The record for Resident 4 was reviewed on 09/13/2022 at 9:03 a.m. Diagnoses included, but were not limited to, hypertension and atrial fibrillation (an irregular heart rhythm). An admission documentation sheet indicated Resident 4 was admitted to the facility on 12/11/2021. 3. The record for Resident 6 was reviewed on 09/13/2022 at 10:01 a.m. Diagnoses included, but were not limited to, cellulitis (a bacterial skin infection). An admission documentation sheet indicated Resident 6 was admitted to the facility on 04/06/2022. During an interview, on 09/13/2022 at 8:54 a.m., the Corporate Support Nurse indicated the facility did not have any policies in place for the Residential Unit and the facility follows all state regulations and guidelines. During an interview, on 09/13/2022 at 2:00 p.m., the Director of Nursing indicated it was the expectation for resident's to receive a 2-step TB test and he could not provide any documentation of this for Residents 1, 4, and 6.		Assisted Living nurse manager regarding placing two-step TB tests upon admission. The systemic change includes education upon hire and annually. DON/designee will audit new admissions to ensure a two-step TB test is placed. Audits will occur daily x 30 days, weekly x12 weeks and monthly x5 months for a total of 9 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	
R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance (i) Persons with a documented history of a			

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	09/14/2022

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
	positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on interview and record review, the facility failed to administer an annual Tuberculin (TB) skin test (a test used to determine if a person had been exposed to Tuberculosis) for 1 of 7 residents reviewed for TB skin testing. (Resident 3) Finding includes: The record for Resident 3 was reviewed on 09/12/2022 at 2:30 p.m. Diagnoses included, but were not limited to, depressive disorder and hypertension. An admission documentation sheet indicated Resident 3 was admitted to the facility on 10/19/2016. A Preventive Health Care Report, dated 08/01/2020 - 08/31/2020, indicated Resident's 3 last TB test was administered on 02/10/2019. During an interview, on 09/12/2022 at 4:30 p.m., the Director of Nursing indicated residents should receive a TB screening or test annually and he could not provide any recent documentation of a TB test or screening for Resident 5 after 2019. During an interview, on 09/13/2022 at 8:54 a.m., the Corporate Support Nurse indicated the facility did	R 0412	Resident 3 has received an annual TB test. Residents residing in the community have the potential to be affected by the alleged deficient practice and have been audited to ensure they have received an annual TB test. Education will be provided to the Assisted Living nurse manager regarding annual TB tests. Systemic change includes education upon hire and annually. DON/designee will audit 5 residents to ensure annual TB's are being maintained. Audits will occur daily x 30 days, weekly x12 weeks and monthly x5 months for a total of 9 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration	10/14/2022

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	09/14/2022

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
	not have any policies in place for the Residential Unit and the facility follows all state regulations and guidelines.		will be determined by the Quality Assurance Committee.	