

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2022

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155841		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 08/09/2022	
NAME OF PROVIDER OR SUPPLIER COPPER TRACE HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1250 W 146TH STREET WESTFIELD, IN 46074			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	<p>This visit was for the Investigation of Complaint IN00386581.</p> <p>Complaint IN00386581 - Substantiated. Federal/state deficiencies related to the allegations are cited at F684.</p> <p>Survey dates: August 8 and 9, 2002</p> <p>Facility number: 013556 Provider number: 155841 AIM number: 201341880</p> <p>Census Bed Type: SNF/NF: 77 SNF: 21 Total: 98</p> <p>Census Payor Type: Medicare: 15 Medicaid: 60 Other: 23 Total: 98</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review was completed on August 15, 2022.</p>			F 0000	<p>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.</p>		
F 0684 SS=D Bldg. 00	<p>483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive</p>						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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 disclosable 30 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2022

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155841		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 08/09/2022	
NAME OF PROVIDER OR SUPPLIER COPPER TRACE HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1250 W 146TH STREET WESTFIELD, IN 46074			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.</p> <p>Based on observation, interview and record review, the facility failed to obtain a treatment order, document in the medical record and notify the physician of a non-pressure wound for 1 of 3 residents reviewed for quality of care. (Resident B)</p> <p>Finding include:</p> <p>On August 08, 2022 at 1:41 p.m., Resident B was observed to have a pink colored, square foam dressing and Coban (self-adherent elastic wrap) on her right hand with 8/5 written in black on the dressing (dressing had an adhesive border). At that time, Resident B indicated the nurse was to change the dressing this afternoon.</p> <p>During an interview, on August 08, 2022 at 2:07 p.m., RN 4 indicated the dressing was to be changed that day. When asked what the treatment order was, she was not able to locate the order.</p> <p>The record for Resident B was reviewed on August 08, 2022 at 2:45 p.m. Diagnoses included, but were not limited to, weakness, age related physical debility and displaced fracture of lateral malleolus of left femur (ankle fracture).</p> <p>There was no "Skin Integrity Event" found at the time of the record review.</p> <p>There were no treatment orders found at the time of the record review.</p> <p>There was no documentation of the skin tear or event found at the time of the record review.</p>			F 0684	<p>I. MD was notified of non-pressure wound to resident B's hand, treatment order obtained, and documentation added to the medical record.</p> <p>II. Residents with non-pressure wounds have the potential to be affected by the alleged deficient practice and have been audited to ensure the MD was notified, a treatment order is obtained, and documentation is added to the medical record.</p> <p>III. Licensed nurses will be re-educated regarding wound management of non-pressure wounds including MD notification, obtaining treatment orders and documenting in the medical record. Education will occur upon hire and annually.</p> <p>IV. DON or designee will perform random skin assessments on 5 residents daily to ensure non-pressure wounds have MD notification, treatment orders and documentation in the medical record. Audits will occur daily, M-F, x 30 days, weekly x 12 weeks and monthly x 6 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</p>		08/26/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2022
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155841		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 08/09/2022	
NAME OF PROVIDER OR SUPPLIER COPPER TRACE HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>During an interview, on 08/09/22 at 1158 a.m., the Director of Nursing indicated an event should have been completed with the measurement of the wound and how it happened. Notification to the doctor and family should have been completed and a treatment should have been ordered.</p> <p>During the exit conference, with the Executive Director and Director of Nursing, on August 09, 2022 beginning at 12:11 p.m., the Director of Nursing indicated the resident informed him the skin tear happened over the weekend, Saturday (08/06/2022), and she did not know how it occurred.</p> <p>The dressing was dated 08/05/2022 and not 08/06/2022.</p> <p>An email correspondence, provided by the Director of Nursing, on August 09, 2022 at 11:51, indicated nursing may apply a non-adherent (did not stick) occlusive (no air or moisture can penetrate) dressings to minor cuts, scrapes and skin tears as a nursing measure and did not require a physician's order. The email had a printed name of Nurse Practitioner 3 and the date of the email was August 09, 2022 at 11:20 a.m.</p> <p>A facility policy, titled "Skin Assessment Policy," dated February 1, 2019 and provided by the Director of Nursing on August 09, 2022, indicated "...If a new skin condition is identified by a licensed nurse...the nurse will open the appropriate "Skin Integrity Event"...and complete all required sections...The licensed nurse that discovers a new open area will perform the following actions:...Notify the MD, obtain and enter a treatment order...Document...in the medical record...."</p>				100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2022
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155841		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 08/09/2022	
NAME OF PROVIDER OR SUPPLIER COPPER TRACE HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP COD 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
	This Federal Tag relates to Complaint IN00386581. 3.1-37(a)						