| 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 _____ | C 02/10/2025 |

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

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| F 000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaint IN00450891.<br><br>Complaint IN00450891-Federal/State deficiencies related to the allegations are cited at F689.<br><br>Survey date: February 10, 2025<br><br>Facility number: 013556<br>Provider number: 155841<br>AIM number: 201341880<br><br>Census bed type:<br>SNF: 35<br>SNF/NF: 76<br>Residential: 62<br>Total: 173<br><br>Census payor type:<br>Medicare: 25<br>Medicaid: 52<br>Other: 34<br>Total: 111<br><br>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review was completed on February 18, 2025. | F 000 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and | F 689 | | |

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 90 days 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 14 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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| F 689 | Continued From page 1<br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure a resident was transferred with a gait belt to prevent a fall according to the policy and procedure for 1 of 3 residents reviewed for accidents. (Resident B) The deficient practice was corrected on 1/16/25, prior to the start of the survey, and was therefore past noncompliance.<br><br>Findings include:<br><br>A document titled "Indiana State Department of Health Survey Report System," indicated CNA 2 was assisting Resident B to transfer, the resident lost her balance, and the CNA assisted the resident to the floor. The resident complained of pain to her left lower extremity and X-rays were obtained at the facility. The X-ray results indicated Resident B had a left femoral neck fracture. The party responsible for the resident decided to keep her at the facility and not to proceed with surgical intervention. She remained in hospice services. Additional education was provided to CNA 2 on the use of a gait belt and safe transfers.<br><br>The record for Resident B was reviewed on 2/10/25 at 11:03 a.m. The diagnoses included, but were not limited to,<br>pain, difficulty in walking, attention and concentration deficit, dementia, hypocalcemia, and unsteadiness on feet.<br><br>A nursing progress note, dated 1/7/25 at 8:10 a.m., indicated RN 3 was alerted by a CNA to come to Resident B's room as the resident had | F 689 | Past noncompliance: no plan of correction required. | |

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| F 689 | Continued From page 2 | F 689 | | |

fallen. CNA 2 was getting the resident up for the day from the bed when the resident lost her balance due to bilateral lower extremity weakness and they fell. The resident and CNA 2 were found on the floor by the resident's bed. CNA 2 and the resident denied the resident hit her head. The resident initially did not complain of any pain, however after about an hour she complained of pain to her left lower extremity. The hospice provider was notified.

A facility document, titled "The Fall Huddle," undated, indicated on 1/7/25 at 8:10 a.m., Resident B had an assisted fall. The CNA was assisting Resident B to get up for the day when she lost her balance due to bilateral lower extremity weakness. CNA 2 was not using a gait belt at the time when the resident had the assisted fall.

A nursing progress note, recorded as a late entry on 1/9/25 at 11:46 a.m., indicated Resident B's X-rays results of her pelvis and left hip indicated an impacted and minimally displaced subcapital femoral neck fracture and soft tissue swelling overlayed the fracture. The resident's family wished to not seek treatment at this time.

A nursing progress note, dated 1/9/25 at 11:46 a.m., indicated RN 3 spoke with a family member in the resident's room. The family member confirmed again today that the resident would continue with hospice care and comfort medications and would not seek treatment for the impacted and minimally displaced subcapital femoral neck fracture.

An Interdisciplinary team (IDT) progress note, dated 1/10/25 at 7:37 a.m., indicated CNA 2 was

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| F 689 | Continued From page 3 | F 689 | | |

getting Resident B up for the day from bed on 1/7/25 when the resident lost her balance due to bilateral lower extremity weakness. The resident and CNA 2 were found on the floor by the resident's bed. CNA 2 and the resident denied the resident hit her head. She had incontinent care provided prior to the transfer. The root cause of the fall was the resident's overall decline, and she lost her balance. The intervention initiated by IDT would be to provide two persons transfer with a gait belt.

During an interview, on 2/10/25 at 11:20 a.m., the Director of Nursing indicated CNA 2 should have used a gait belt during the transfer.

During an interview, on 2/10/25 at 11:37 a.m., CNA 2 indicated she went to get Resident B out of bed for the day. She stood her up, so she could pivot her into the wheelchair. The resident moved one of her legs back, then she fell backwards on top of CNA 2. CNA 2 yelled for help, but no one came, so she got her cell phone and called another CNA to come and help her. She did not place a gait belt on Resident B prior to transferring her and she should have had a gait belt on her.

A facility document, titled "Using a Gait Belt to Assist with Ambulation," was signed by CNA 2 on 1/16/25, and indicated "...Place belt around resident's waist with the buckle in front (on top of resident's clothes) and adjust to a snug fit ensuring that you can get your hands under the belt. Position one hand on the belt at the resident's side and the other hand at the resident's back. 4. Assist the resident to stand on count of three. 5. Allow the resident to gain balance. Ask the resident if dizzy. 6. Stand to

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| F 689 | Continued From page 4 | F 689 | | |

side and slightly behind resident while continuing to hold onto belt...."

A current facility policy, titled "Procedure #26: Transfer to Wheelchair," undated and provided by the Director of Nursing on 2/10/25 at 11:30 a.m., indicated "...Stand in front of resident and apply gait belt around the resident's abdomen. 5. Grasp the gait belt securely on both sides of the resident...11. Align resident's body and position footrests. Remove gait belt...."

The deficient practice was corrected by 1/16/25, after the facility implemented a systemic plan which included CNA 2 was given additional education on transferring a resident while using a gait belt, all nursing staff was all educated on transferring a resident to a wheelchair and using a gait belt, and transfers with a gait belt audits were being completed daily by the Director of Nursing.

This citation relates to Complaint IN00450891.

3.1-45(a)(2)