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	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copper Trace Health & Living Community	1250 W 146th Street Westfield, IN 46074

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was discharged to a location which met the resident's needs and provided the support and resources needed for 1 of 3 residents reviewed for discharge. (Resident B)Findings include:The clinical record for Resident B was reviewed on 10/27/25 at 10:05 a.m. The diagnoses included, but were not limited to, risk for malnutrition, dementia with psychotic and mood disturbance, memory deficit, speech and language deficits, dysphagia, pain, anxiety disorder, hypertension, difficulty walking, and age-related macular degeneration.A speech therapy note, dated 9/4/25 at 9:43 a.m., indicated Resident B was severely cognitively impaired and required a mechanically ground diet. A physician's history and physical note, dated 9/4/25 at 3:22 p.m., indicated Resident B reported a 10-15-pound weight loss in one (1) month and currently weighed 78 pounds. Resident B had impaired cognition/dementia at the hospital, anxiety, constipation, insomnia, and macular degeneration. The hospital had been concerned Resident B was unable to care for herself and reported possible self-neglect to APS (adult protective services). Resident B had a brother in Florida and a local friend which she did not see often. While in the hospital, Resident B had extreme anxiety and cognitive difficulties.A Montreal Cognitive Assessment (MOCA), dated 9/4/25, indicated Resident B scored 6 out of a 30, and normal cognition was considered a score of 26 or more.A care conference summary, dated 9/5/25, indicated the Social Services Director (SSD) discussed options for Resident B such as hiring caregivers, assisted living facility, or long-term care. Resident B's brother indicated the resident could not afford any of those options. He believed she had some support from a few friends. No names or contact information was given. There was no documentation, a discussion of Medicaid applications or offers to assist with the application process was completed.A Preadmission Screening and Resident Review (PASRR) level I assessment, dated 9/12/25, indicated the level I showed Resident B had evidence of a primary neurocognitive disorder/dementia. Further PASRR evaluation was not required because Resident B's neurocognitive disorder/dementia was so progressed, it was the primary condition which required treatment.A psychiatric physician's progress note, dated 9/23/25, indicated Resident B's memory, insight, judgement, and nutritional status was poor. Her mood was dysphoric at times, and her thought processes were confused. Her diagnoses included moderate major neurocognitive disorder with psychotic disturbances, anxiety, and mood symptoms.A physician's order, dated 10/1/25, indicated Resident B could discharge home, on 10/3/25, with current medications and home health. Therapy to evaluate and treat.A speech therapy Discharge summary, dated [DATE], indicated Resident B's ability to manage activities of daily living such as taking medications safely and independently was moderate to severely impaired. Resident B had a moderately severe cognitive decline/possible dementia. Her cognitive problem solving and short-term memory was impaired. The discharge recommendations were for the resident to have supervision and assistance with medication management to ensure she was taking appropriate dosages and to utilize a pillbox to assist her. It was recommended for Resident B to have visual cues throughout her apartment to complete tasks such as taking her medicine and locking the door. She was not considered safe to use the stove and needed to have a calendar to help her remember appointments. Her discharge diet was minced and moist. The summary indicated Resident B was being discharged to live alone with no assistance or support.The clinical record did not contain documentation of an assessment of Resident B's ability to prepare minced and moist food for herself. There was no documentation caregivers were educated about providing Resident B with cues or minced and moist food options.A social services progress note, dated 10/2/25 at 8:54 p.m., indicated Resident B's last covered day by her managed Medicare plan was 10/3/25, so she would discharge on that day. Resident B's health literacy (defined by the CDC as the degree to which individuals had the ability to find, understand, and use information and services to make inform health-related decisions and actions for themselves) was sometimes. Resident B's brother was notified of the discharge date and home health was set up. There was documentation the brother received discharge paperwork, and the brother did not sign the discharge paperwork.An occupational therapy Discharge summary, dated [DATE], indicated Resident B required supervision or touching assistance to safely and efficiently bathe, including washing, rinsing, and drying with the use of a long-handled sponge and shower chair. Resident B had a medical history of failure to thrive with no social support at home. The resident was anxious about returning home. Resident B was discharged from skilled occupational therapy due to insurance denied coverage and she would be returning home alone with no

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure specific discharge instructions related to the resident's current cognitive status and memory deficit, medication administration, and food preparation needs were provided to the home health provider for 1 of 3 residents reviewed for discharge. (Resident B)Findings include:The clinical record for Resident B was reviewed on 10/27/25 at 10:05 a.m. The diagnoses included, but were not limited to, risk for malnutrition, dementia with psychotic and mood disturbance, memory deficit, speech and language deficits, dysphagia, pain, anxiety disorder, hypertension, difficulty walking, and age-related macular degeneration.A physician's order, dated 10/1/25, indicated Resident B could discharge home, on 10/3/25, with current medications and home health.A speech therapy Discharge summary, dated [DATE], indicated the recommendations were for Resident B to have supervision and assistance with medication management to ensure she was taking appropriate dosages and to utilize a pillbox to assist her. It was recommended for Resident B to have visual cues throughout her apartment to complete tasks such as taking her medicine and locking the door. She was not considered safe to use the stove and needed to have a calendar to help her remember appointments. Her discharge diet was minced and moist. The summary indicated Resident B was being discharged to live alone with no assistance or support.A social services progress note, dated 10/2/25 at 8:54 p.m., indicated Resident B's health literacy (defined by the CDC as the degree to which individuals had the ability to find, understand, and use information and services to make inform health-related decisions and actions for themselves) was sometimes and home health was set up.An occupational therapy Discharge summary, dated [DATE], indicated Resident B required supervision or touching assistance to safely and efficiently bathe, including washing, rinsing, and drying with the use of a long-handled sponge and shower chair. Resident B had a medical history of failure to thrive with no social support at home.A physical therapy Discharge summary, dated [DATE], indicated the resident needed a walker to safely ambulate. The resident indicated she had a walker at home.A Brief Interview for Mental Status (BIMS) assessment, dated 10/3/25, indicated Resident B had severe cognitive impairment.A transition of care/Discharge summary, dated [DATE], indicated Resident B was not responsible for herself and listed contact information for a home healthcare provider. The summary indicated Resident B was cognitively impaired and needed assistance with eating, oral, toileting, and personal hygiene, upper and lower body dressing, rolling left and right, sitting to standing, and toilet and shower transfers. It did not include any medication instructions. It did not include therapy notes, speech therapy recommendations, the use of a rolling walker, or local caregiver contact information. It was signed by Resident B.A nursing progress note, dated 10/3/25 at 12:09 p.m., indicated Resident B was discharged home with all medications. The discharge paperwork and instructions were gone over with the resident only and she signed the paperwork. The facility driver transported the resident home alone.There was no documentation to indicate anyone else was present in the apartment to see the discharge instructions, set up the resident's medication, help the resident with visual cues and reminders, or get her groceries.A Minimum Data Set (MDS) assessment, dated 10/3/25, indicated Resident B was discharged home. It did not indicate the resident was discharged home under the care of an organized home health service or a current reconciled medication list was provided to the subsequent provider.A facility referral packet indicated the home health care provider was provided with a face sheet, current orders, and the facility physician's history and physical. It did not include care plan information, speech therapy notes, occupational therapy notes, physical therapy notes, or psychiatric physician notes.A home health initial visit note, dated 10/8/25 at 3:23 p.m., indicated Resident B was oriented to self and place, forgetful, confused, anxious, and depressed. There was no capable caregiver present, inadequate environmental cleaning, and no support network available. The resident indicated she felt isolated and alone most of the time. Resident B had poor hygiene, hydration, nutrition, and mobility. Resident B required assistance with walking and all activities of daily living, including basic grooming. Resident B required 24-hour supervision, but no supervision was available. She could not manage her medications without supervision and was not taking her medications. She was not eating and indicated she was constipated and in pain.A hospital history and physical note, dated 10/9/25, indicated Resident B was brought to the emergency room by emergency medical services (EMS). She had a new T12 compression fracture in her back. She did not remember falling. The resident was confused and did not know who had called EMS. She was confused about her medical history and reported she had only been drinking