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	01/08/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49891 Based on interview and record review, the facility failed to ensure a blood pressure medication was held according to the physician's ordered hold parameter, to give an ordered antibiotic prior to a dental visit, and to treat an elevated blood sugar with the physician's ordered sliding scale for 3 of 3 residents reviewed for quality of care. (Resident 256, 4 and 52) Finding includes: 1. The clinical record for Resident 256 was reviewed on 1/2/25 at 10:29 a.m. The diagnoses included, but were not limited to, anemia, essential primary hypertension, and memory deficit following other cerebrovascular disease. A physician's order, dated 12/27/24, indicated to give lisinopril (a medication to lower blood pressure) 10 milligrams (mg) tablet once a day, with special instructions to hold the medication for a systolic blood pressure less than 140. A Medication Administration Record (MAR), dated 12/27/24 through 1/7/25, indicated lisinopril 10 mg was not held according to the physician's order on the following dates: a. On 12/28/24, with a systolic blood pressure of 132. b. On 12/31/24, with a systolic blood pressure of 112. c. On 1/1/25, with a systolic blood pressure of 124. d. On 1/5/25, with a systolic blood pressure of 137. e. On 1/6/25, with a systolic blood pressure of 108. f. On 1/7/25, with a systolic blood pressure of 134. The electronic medical record did not include documentation the physician had been notified of the lisinopril administrations when the systolic blood pressure was below the hold parameter of 140. (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 1/7/25 at 11:55 a.m., RN 7 indicated the staff initials would be in parenthesis on the MAR when the medication had not been given. If there were no parenthesis around the initials, then the medication had been given. During an interview, on 1/7/25 at 3:00 p.m., the Director of Nursing (DON) indicated the lisinopril dose was given on the listed dates against the physician's ordered hold parameter. 44598 2. The clinical record for Resident 4 was reviewed on 1/3/25 at 12:16 a.m. The diagnoses included, but were not limited to, angina pectoris, chronic artery disease, congestive heart disease, hypertension, myasthenia gravis, depression, and anxiety disorder. A physician's order, dated 12/17/24, indicated azithromycin (an antibiotic) 500 mg (milligrams) tablet was to be given prior to dental appointments and cleanings. A progress note, dated 12/17/2024 at 2:02 p.m., indicated the resident was seen by the dental hygienist on 12/17/24. The resident's Medication Administration Record (MAR) indicated the medication was to be given prior to the resident's dental appointment and was not signed off by the nurse. During an interview, on 1/7/25 at 11:53 a.m., the Minimum Data Set (MDS) Coordinator indicated she would need to check why the antibiotic (ATB) was not signed off. The nurse should have signed the medication off on the Medication Administration Record (MAR) when it was given. During an interview, on 1/7/25 at 1:35 p.m., the Clinical Support Nurse indicated the medication was not signed off on the MAR. The nurse should have signed the medication off in the MAR after giving the medication. There was no way to prove the ATB was given prior to going to the appointment. 38872 3. The clinical record for Resident 52 was reviewed on 1/6/25 at 9:48 a.m. The diagnoses included, but were not limited to, type 2 diabetes without complications, type 2 diabetes mellitus with ketoacidosis (high levels of ketones cause the blood to become more acidic) without coma, and dementia. A physician's order, initiated on 7/21/24, indicated to check the resident blood sugar before meals and at bedtime and to notify the physician if the blood sugar was less than 60 or greater than 400. A physician's order, initiated on 7/21/24, indicated to check the resident's blood sugar prn (as needed) for symptoms of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugars) and to notify the physician if the blood sugar was less than 60 or greater than 400. A physician's order, initiated on 7/21/24, indicated if the blood sugar was less than 60 and the resident could swallow, administer 4 ounces of juice or soda and a short acting carbohydrate. Repeat the blood sugar and notify the physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, initiated on 7/21/24, indicated to give Humalog insulin per the following sliding scale: If the blood sugar was 150 to 190, give 3 units. If the blood sugar was 191 to 230, give 6 units. If the blood sugar was 231 to 270, give 9 units. If the blood sugar was 271 to 310, give 12 units. If the blood sugar was 311 to 350, give 15 units. If the blood sugar was greater than 350, call the physician. A physician's order, initiated on 11/13/24, indicated to give Humalog Insulin 8 units daily at 12:00 p.m. The resident had a documented high blood sugar level of 414, on 11/29/24 at 11:08 a.m. The Medication/Treatment (MAR/TAR) record indicated the physician was notified. There was no progress note found to indicate the physician had given additional orders to treat the high blood sugar. The resident was given the scheduled 8 units at 12:00 p.m. Per the MAR/TAR, zero (0) units of the sliding scale were given for the resident's high blood sugar. There were no additional orders found for the treatment of the high blood sugar. The resident's blood sugar level was checked on 11/29/24 at 4:00 p.m., and the residents blood sugar was 453. During an interview, on 1/8/25 at 2:12 p.m., the Clinical Support Nurse indicated the documented 0 units for the sliding scale was most likely an error. At this time, any progress notes and any orders which pertained to holding or giving additional insulin were requested. A nursing progress note, dated 12/12/24 at 8:05 a.m., indicated Resident 52 had a blood sugar result of 50. The resident was given two (2) eight-ounce glasses of orange juice and the blood sugar was rechecked 30 minutes later. There was no documentation to indicate the physician had been notified of the low blood sugar. The blood sugar was not documented on the Medication/Treatment record or under the vital signs. During an interview, on 1/8/25 at 2:33 p.m., RN 8 indicated if a resident was found to have a high or low blood sugar, the staff would notify the physician and follow the orders for the hyper/hypoglycemia protocol. No additional information was provided by the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility procedure, titled Obtaining a Fingerstick Glucose Level, dated as last revised in April 2001 and received from the Corporate Support Nurse on 1/8/25 at 2:12 p.m., indicated .Follow facility policies and procedures for appropriate nursing interventions regarding blood sugar results .Report abnormal results promptly to the Attending Physician A current facility policy, titled Medication Administration: General Policies and Procedures, not dated and received from the Administrator on 1/7/25 at 12:15 p.m., indicated .Medications are administered as prescribed in accordance with good nursing principles and practices .All medications are to be administered only as prescribed by a physician .Medication errors .shall be immediately reported to the attending physician, charted in detail in the resident's medical record and described in a full incident report A current facility policy, titled Protocol for Following Physician Orders, dated 4/3/17 and received from the Administrator on 1/6/25 at 10:43 a.m., indicated .All licensed staff will verify and follow the physician orders as written 3.1-37(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 49891 Based on interview and record review, the facility failed to ensure catheter urine output was accurately recorded and to document the removal of a urinary catheter with post-removal bladder scan measurements for 2 of 2 residents reviewed for urinary catheters. (Resident 258 and 259) Findings include: 1. The clinical record for Resident 258 was reviewed on 1/3/25 at 11:36 a.m. The diagnoses included, but were not limited to, aphasia following cerebral infarction, memory deficit, stage 3 chronic kidney disease, depression, hypotension, neuromuscular dysfunction of bladder, chronic myeloid leukemia, type 1 diabetes mellitus, and Alzheimer's disease. A physician's order, with a start date of 12/23/24, indicated to empty the Foley catheter every shift and to document the output. A current care plan, with a start date of 12/23/24, indicated to accurately document outputs on the flowsheet every shift. A Treatment Administration Record (TAR), dated 12/23/24 through 1/3/24, indicated to empty the Foley catheter every shift and document the output. On 12/23/24, the night shift had no output recorded. On 12/24/24, the day and evening shifts had medium urine outputs recorded. On 12/25/24, the evening shift had medium recorded, and the night shift had large recorded. On 12/26/24, the day and evening shift had large recorded. On 12/27/24, the evening shift had medium recorded. On 12/28/24, the evening shift had medium recorded. On 12/29/24, the evening shift had large recorded. On 12/30/24, the evening shift had medium recorded. On 12/31/24, the day shift had large recorded, and the evening shift had medium recorded. On 1/3/25, the day shift had none recorded, the evening shift had small recorded, and the night shift had small/150ml recorded. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 1/7/25 at 12:06 p.m., RN 7 indicated she did not know why the exact urine amount was not documented when the CNAs (certified nursing assistant) were emptying the catheter in a graduated cylinder. They should not have been using small, medium, and large for the urine output amounts. During an interview, on 1/7/25 at 3:00 p.m., the Director of Nursing (DON) indicated if there was an order to document outputs then it should have been the actual amount which was charted. 2. The clinical record for Resident 259 was reviewed on 1/7/25 at 11:32 a.m. The diagnoses included, but were not limited to, urinary tract infection and retention of urine. A care plan, with a start date of 12/19/24, indicated to accurately document intakes and outputs. A care plan, with a start date of 1/1/25, indicated the resident had an indwelling urinary catheter. A nurse practitioner's progress note, dated 12/23/24, indicated the resident had significant post void residuals and urology had placed the Foley catheter while the resident was in the hospital. The plan was to order a voiding trial on Friday, 12/27/24. A physician's order, dated 12/20/24 and discontinued 12/29/24, indicated to obtain the Foley catheter output every shift. A physician's order, dated 12/27/24 and discontinued 12/30/24, indicated to remove the Foley catheter and complete a bladder scan every 8 hours. A TAR, dated 12/20/24 through 1/8/25, indicated to record the Foley catheter output every shift: On 12/21/24, there was no Foley catheter output for the day or evening shifts. On 12/27/24, there was no Foley output for the day or night shift. A note for the night shift indicated not administered due to item not being present. A TAR, dated 12/20/24 through 1/8/25, indicated to remove the Foley catheter and complete a bladder scan every 8 hours. On 12/27/24, no treatment was recorded for the day or evening shift, and small was recorded for the night shift. The comments for no treatment on the day and evening shift were other. On 12/28/24, no treatment was recorded for the night shift with the comment Foley removed. On 12/29/24, no treatment was recorded for the day shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 1/7/25 at 2:41 p.m., the DON indicated staff should document the amount of urine in milliliters when there was a physician's order to document output. When staff discontinued a catheter, there should be a note in the progress notes. She was unable to find a note regarding the removal of the catheter except for the notes in the MAR which indicated the catheter was not present or had been discontinued. The notes were confusing with some shifts saying the catheter was present after a previous shift appeared to indicate it was discontinued. The DON indicated she thought the catheter was removed some time on 12/27/24. There were missing bladder scan recordings but without knowing exactly when the catheter was removed, she could not determine exactly how many. A current skills validation procedure, titled Measuring and Recording Intake and Output Skills Validations, and received from the DON on 1/7/25 at 3:00 p.m., indicated .Resident's with Foley Catheters are emptied every shift .The bag should be emptied per protocol into either a graduated drainage cup or urinal .After the fluid is gathered, the container should be held at eye level to view the level of the fluid and the amount obtained should be recorded for later documentation into the resident's permanent medical record . Document .source of .output and volumes 3.1-41(a)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. 44598 Based on interview and record review, the facility failed to ensure a weight gain was reviewed when a resident had a documented weight gain of 5.56% in 1 month for 1 of 4 residents reviewed for nutrition. (Resident 9) Finding includes: The clinical record for Resident 9 was reviewed on 1/3/25 at 10:48 a.m. The diagnoses included, but were not limited to, thyroid disorder, muscle weakness, anorexia, bipolar disorder, and paranoid schizophrenia. A weight log indicated the resident had the following weights: 1. On 9/2/24, the weight was 140.30 pounds. 2. On 10/1/24, the weight was 148.10 pounds which was a significant weight gain of 5.56% in 1 month. A current physician's order, dated 4/13/23, indicated to give Ensure Plus lactose reduced (a dietary supplement to provide additional calories) 237 milliliters (ml) three times a day. A current physician's order, dated 10/16/23, indicated the resident received a regular diet, pureed consistency with gravy or sauce and to add fortified pudding with lunch and dinner. A current physician's order, dated 11/11/24, indicated to give Med pass (a dietary supplement to provide additional calories) 120 ml twice a day with medication pass. A care plan, initiated 10/27/21 and last reviewed on 12/9/24, indicated the resident was at nutritional risk related to a mechanically altered diet. Interventions included, but were not limited to, weights per physician's order, provide assistance with meals, supplements as ordered, monitor weight routinely and notify the physician and the Registered Dietician (RD) of significant weight changes. During an interview, on 1/8/25 at 11:18 a.m., QMA 2 indicated the resident needed assistance when eating. The resident was a good eater and ate almost all her food. During an interview, on 1/8/25 at 2:31 p.m., the Clinical Support Nurse indicated the facility thought the weight in September was incorrect. The resident was not weighed again until 10/1/24. She did not know why the resident was not re-weighed after the gain. The Registered Dietician was just now looking at the resident's information. During an interview, on 1/8/25 at 2:34 p.m., RN 8 indicated first she would figure out how the resident was weighted. If the resident was weighed in a wheelchair, the weight of the wheelchair was subtracted from the weight of the resident. If the weight was still significantly high, then the Nurse Practitioner and Registered Dietitian should have been notified, and everything would be documented in the medical record. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A current policy, titled Weight Management Policy, dated 2/17/15 and received from the Clinical Support Nurse on 1/8/25 at 2:25 p.m., indicated .Significant weight change is defined as: 5% loss/gain in 30 days .7. 5% loss/gain in 90 days .Significant weight changes will be reviewed by the IDT by the 10th day of each month to ensure timely interventions are implemented to prevent further unwanted loss/gains .Significant weight loss/gain protocol (for weekly admission weights and routine monthly weight monitoring and any other weight change the IDT determines to be at risk) .Family/physician/RD notification will be documented in the medical record .The RD will be notified to assess/review the resident for recommendations on his/her next visit. IDT will meet weekly on residents with significant weight changes to evaluate the current interventions and make changes as necessary to stabilize the resident and attain the care plan goal 3.1-46(a)(1)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44598 Based on observation, interview and record review, the facility failed to ensure oxygen equipment was turned on and the physician's orders were followed for 1 of 3 residents reviewed for respiratory care. (Resident 66) Finding includes: During an observation, on 1/2/25 at 11:21 a.m., Resident 66 was sitting in her recliner wearing oxygen tubing. The resident was having a hard time breathing and was not getting supplemental oxygen. The oxygen concentrator (a device used to provide supplemental oxygen therapy) was not turned on. During an observation, on 1/2/25 at 11:23 a.m., LPN 3 entered the room and checked the oxygen concentrator. The nurse turned on the concentrator and left the room to get the vitals machine to check the resident oxygen saturation. The nurse attached the pulse oximeter to the resident's finger and the resident's saturation was 82%. During an observation, on 1/2/25 at 12:51 p.m., Resident 66's door was closed, and a high-pitched whistling noise was heard coming from the resident's room. The oxygen concentrator had a red light on the top of the machine, the humidity bottle was not bubbling, and the concentrator was making a high-pitched sound. The nurse entered the room and indicated the concentrator was not working. The Minimum Data Set (MDS) Coordinator entered the room to assist the nurse. A new concentrator was brought into the room and the resident's oxygen tubing was attached. The nurse turned the oxygen on 2.5 L (liter/min). The nurse took the resident's oxygen saturation, and it was 82%. During an observation, on 1/2/25 at 12:55 p.m., the MDS Coordinator indicated the physician's order was for continuous oxygen at 3L via nasal canula. The oxygen concentrator was switched to 3L. The clinical record for Resident 66 was reviewed on 1/3/25 at 9:24 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), pneumonia, and heart failure. A care plan, dated as revised 12/5/24, indicated the resident was on oxygen therapy. Interventions included, but were not limited to, administer oxygen as ordered and monitor lung sounds. A physician's order, dated 2/20/23 and discontinued on 1/3/25, indicated continuous oxygen at 3L. A physician's order, dated 1/3/25, indicated may titrate oxygen (0-4 liter/min) to maintain oxygen saturation greater than 88%. During an interview, on 1/2/25 at 11:30 a.m., LPN 3 indicated the resident was on 3L and needed the oxygen to assist with her breathing. The resident had returned from a physician's appointment. LPN 3 was not aware of the time she returned or how long the resident was without oxygen. The resident had COPD and needed the oxygen to help her breath. When the concentrator was turned off, the resident was not receiving any supplemental oxygen and the resident's oxygen level was low. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 1/2/25 at 12:51 p.m., LPN 3 indicated she could not hear the concentrator making high pitch sounds when sitting at nurses' station. She thought the concentrator had stopped working. During an interview, on 1/2/25 at 12:53 p.m., the MDS Coordinator indicated the oxygen concentrator was set on 2.5L and the machine was increased to the physician ordered amount. A current policy, titled Protocol for Following Physician Orders, dated 4/3/17 and received from the Administrator on 1/6/25 at 10:43 a.m., indicated .All licensed staff will verify and follow the physician orders as written. If for any reason, the physician order cannot be followed, the licensed professional will contact the physician for further instructions .The resident's plan of care will reflect the physicians order and direction for the resident's plan of care .Upon discontinuation of the physician's order, the resident's plan of care will be updated to reflect the new resident orders A current policy, titled Oxygen Administration, dated 3/2004 and received from the Clinical Support Nurse on 1/8/25 at 2:10 p.m., indicated .Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration .Assemble the equipment and supplies as needed .Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute .Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated . Periodically re-check water level in humidifying jar 3.1-47(a)(6)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38872 Based on observation, interview and record review, the facility failed to ensure insulin was labeled with an open date, to lock a medication cart before staff walked away, and to store antifungal nail solution separately from eye drops for 2 of 4 medication carts. (Ambassador Square and Heritage Court) Finding includes: 1. During an observation, on 1/7/25 at 7:51 a.m., a Lantus insulin pen was found for Resident 353. The pen had been previously opened and did not have an open date. During an interview, on 1/7/25 at 7:51 a.m., RN 9 indicated the insulin pen had been used prior and did not have an open date. 2. During a random observation, on 1/3/25 at 3:15 p.m., the Ambassador Square unit medication cart 1 was found unlocked. There were two dietary staff in the dining room with a wall obscuring the view of the cart. The nurse was found at the opposite end of the unit. The medication cart could not be observed from her position. During an interview, on 1/3/25 at 3:19 p.m., RN 10 indicated the cart was to be locked before walking away. 3. During an observation of medication storage, on 1/7/25 at 4:27 p.m., Jublia (an antifungal) topical nail solution was found stored with eye drops in the top drawer of medication cart 2 on the Heritage Court unit. During an interview, on 1/7/24 at 4:32 p.m., QMA 2 indicated the items should not have been stored together. A current facility policy, titled MEDICATION LABELING, provided by the Director of Nursing on 1/2/25 at 3:10 p.m., did not address putting open dates on medications. A current facility policy, titled DRUG STORAGE, undated and received from the Corporate Support Nurse on 1/8/25 at 2:16 p.m., indicated .Medication .carts .are locked or attended by persons with authorized access. 3.1-25(k)(6) 3.1-25(m)