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	12/18/2025

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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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure assessments were completed according to the policy and weights were obtained and documented in the clinical record for 2 of 2 residents reviewed for quality of care. (Resident 42 and 6)Findings include:1. The clinical record for Resident 42 was reviewed on 12/15/25 at 11:29 a.m. The diagnoses included, but were not limited to, major depressive disorder, anxiety disorder, and dementia.A physician's order, dated 5/10/25, indicated to administer olanzapine (an atypical antipsychotic medication) 10 milligrams (mg) one time a day.A care plan, dated 5/6/25, indicated to complete a routine AIMS observation.An Abnormal Involuntary Movement (AIMS) assessment (used to detect, track, and measure the severity of involuntary movements in patients on antipsychotic medications) was completed on 5/9/25.An AIMS assessment was completed on 12/16/25.There was a greater than 6-month lapse between completing the AIMS assessments.During an interview, on 12/16/25 at 3:31 p.m., the Director of Nursing (DON) indicated the staff should complete AIMS assessments quarterly.During an interview, on 12/17/25 at 2:04 p.m., Clinical Support 1 indicated the staff should complete the AIMS assessments every 6 months.A current facility policy, titled Behavioral Health Management Program, dated January 2024 and received from Clinical Support 6 on 12/18/25 at 9:09 a.m., indicated .AIMS monitoring will be done every 6 months after the initial AIMS assessment.2. During an interview, on 12/17/25 at 11:05 a.m., Licensed Practical Nurse (LPN) 3 indicated when a resident was admitted to the facility, the staff would obtain weights for the first 3 days and according to the physician's order. The weights would be documented in either the MAR (Medication Administration Record) or the vitals tab.The clinical record for Resident 6 was reviewed on 12/15/25 at 1:33 p.m. The diagnoses included, but were not limited to, Parkinson's disease, fracture of the right femur, and weakness.A physician's order, dated 5/1/25, indicated to obtain a monthly weight once a day, on the 1st of the month.A Registered Dietitian (RD) note, dated 6/4/25 at 8:14 p.m., indicated to obtain a reweight due to a 35-pound weight gain in 27 days.The reweight was not located in the electronic medical record.The clinical record indicated on 6/23/25, Resident 6 was discharged to the hospital for surgical repair after experiencing a fall and was re-admitted to the facility on [DATE].A readmission weight was not located in the electronic medical record.A physician's order, dated 7/1/25 to 8/5/25, indicated to obtain weekly weights once a day, on Mondays.A care plan intervention, dated 8/12/25, indicated to obtain weights as ordered.A Registered Dietitian note, dated 9/10/25 at 11:13 a.m., indicated to obtain weekly weights for four (4) weeks due to a significant weight loss.A progress note, dated 9/17/25, indicated Resident 6 had a 12-pound weight loss in 27 days with an intervention of weekly weights.A care plan intervention, dated 9/18/25, indicated Resident 6 was a monthly weight.A physician's order, dated 10/14/25 to 11/4/25, indicated to obtain weekly weights for four (4) weeks, once a day on Tuesdays.The vitals tab in the electronic medical record indicated Resident 6's weights were marked as invalid on 4/28/25, 5/5/25, 6/1/25, 6/5/25, 7/3/25, 9/4/25, 9/22/25, 9/25/25, 9/29/25, and 10/1/25.The electronic Medication Administration Record (MAR) indicated the following weight documentation:1. Monthly:On 5/1/25, no weight was documented.On 6/1/25, the weight was documented as invalid.On 9/1/25, no weight was documented.On 10/1/25, the weight was (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	documented as invalid. 2. Weekly:On 6/1/25, the weight was documented as invalid.On 7/16/25, no weight was documented.On 7/28/25, no weight was documented.On 9/15/25, the weight was documented as invalid.On 9/29/25, the weight was documented as invalid.On 10/14/25, no weight was documented. There was no documentation in the MAR to indicate weekly weights were obtained from 7/1/25 to 7/16/25 according to the physician's order. A physician's order or documentation of the weekly weights obtained for four (4) weeks as recommended by the Registered Dietitian, on 9/10/25, was not located in the electronic medical record.During an interview, on 12/17/25 at 11:10 a.m., LPN 5 indicated invalid in the vitals tab and the MAR indicated a reweight had been completed due to a significant loss or gain when compared to the previous weight. When a reweight was obtained, the weight would be documented in the clinical record, and she was not sure why the vitals tab and the MAR did not reflect the reweight.During an interview, on 12/18/25 at 10:12 a.m., the Director of Nursing (DON) indicated she had invalidated Resident 6's weights in the clinical record after obtaining a reweight.A current facility policy, titled Weight Assessment and Intervention, dated as revised December 2008 and received from the Clinical Support Nurse on 12/18/25 at 12:30 p.m., indicated .The nursing staff will measure resident weights on admission and weekly for four weeks thereafter.Weights will be recorded in the resident's medical record.A current facility policy, titled Weight Management Policy, dated March 2015 and received from the DON on 12/18/25 at 9:09 a.m., indicated .Initial weight: upon admission/re-admission.will be inserted into the resident's medical record.4 weeks post admit weights: New admission/re-admission resident's will be weighed at admission and weekly X4 weeks and monthly thereafter if the weight is determined to be stable.If the resident has a previous weight in the medical record that weight will be compared to the current weight being obtained to ensure that a reweight is done immediately if there is a significant change in weight.Significant weight lose/gain protocol.weekly weight monitoring.Documenting resident compliance/non-compliance.Document refusals, document refusals of alternatives and document the resident has the right to refuse once all alternative options are offered.3.1-37(a)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure consents were obtained and the ability to safely use an enabler bar for bed mobility and transfers assessments were completed for 2 of 7 residents reviewed for accident hazards. (Resident 115 and 11)Findings include:1. During an observation, on 12/11/25 at 12:03 p.m., Resident 115 was in bed and had bilateral grab bars. During an observation, on 12/12/25 at 2:02 p.m., Resident 115 was in bed and had bilateral grab bars. During an observation, on 12/15/25 at 10:04 a.m., Resident 115 was in bed and had bilateral grab bars. During an observation, on 12/16/25 at 10:32 a.m., Resident 115 was in bed and had bilateral grab bars. The clinical record for Resident 115 was reviewed on 12/12/25 at 2:31 p.m. The diagnoses included, but were not limited to, difficulty in walking, insomnia, memory deficit following cerebrovascular disease, mild dementia with mood disturbance, speech and language deficits following cerebrovascular disease, and Alzheimer's disease. A care plan, dated 11/4/25, indicated transfer bars were used while in bed to aid in transfers and bed mobility. A physician's order, dated 12/8/25, indicated Resident 115 used mobility devices. A speech language pathology report, dated 12/9/25 at 7:05 a.m., indicated Resident 115 had severe cognitive impairment. A care plan meeting summary, dated 12/12/25, did not include the transfer assist rails being discussed with the resident's representative. A bed rail assessment dated [DATE] 10:46 a.m., (completed after the start of the survey) indicated the resident required an assist rail for transfers. The assessment did not indicate the type of rail used, the risks and benefits, alternatives initiated prior to use, consent, or a safety assessment of Resident 115's ability to use the assist rails. A progress note, dated 12/16/25 at 12:30 p.m., indicated Resident 115 gave verbal consent for the use of the assist rails on his bed. The risks and benefits had been discussed with Resident 115. The electronic medical record did not include a bed rail consent from the resident's representative and did not include the required safety assessment. During an interview, on 12/17/25 at 10:15 a.m., the Director of Nursing (DON) indicated Resident 115 had a bedrail assessment completed, on 12/16/25, and consent was obtained. During an interview, on 12/15/25 at 2:59 p.m., the Executive Director (ED) indicated Resident 115 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was very confused. During a previous incident, he had called 911 and told them he had fallen and was on the floor, but he was safe in the bed and had not fallen. 2. During an observation, on 12/12/25 at 11:28 a.m., Resident 11's bed had bilateral grab bars. The grab bars were attached to the bed frame and could not be lowered from their raised position. The clinical record for Resident 11 was reviewed on 12/12/25 at 2:52 p.m. The diagnoses included, but were not limited to, dementia, repeated falls, and Parkinson's disease with dyskinesia (involuntary, erratic muscle movements, ranging from mild fidgeting to severe writhing, often affecting the face, limbs, or trunk). A care plan, dated 3/25/25, indicated Resident 11 was unable to independently perform activities of daily living. An intervention indicated to utilize transfer bars while in bed to aid in transfers and bed mobility. The electronic health record did not include a bed rail assessment or consent for the use of bed rails at the time of the clinical record review. During an interview, on 12/16/25 at 9:45 a.m., the Clinical Support Nurse indicated the facility would not have consents or assessments for the enabler bars or transfer bars. During an interview, on 12/17/25 at 10:45 a.m., the Clinical Support Nurse indicated the beds were delivered to the facility with the rails already attached, not added to the bed due to the residents' decline resulting in a need for them, therefore consents and assessments were not done. A current facility policy, titled Proper Use of Side Rails, dated as last revised December 2007 and received from the Clinical Support Nurse on 12/16/25 at 10:52 a.m., indicated .The purpose of these guidelines are to ensure the safe use of side rails as resident mobility aids.Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents.An assessment will be made to determine the resident's symptoms or reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: bed mobility; and.Ability to change positions, transfer to and from bed or chair, and to stand and toilet.Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks. 3.1-45(a)(1) 3.1-45(a)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure medication was available and administered as ordered by the physician for 1 of 6 residents reviewed for pharmacy services. (Resident 116)Findings include:The clinical record for Resident 116 was reviewed on 12/16/25 at 10:57 a.m. The diagnoses included, but were not limited to, Parkinson's disease, difficulty walking, unsteadiness on feet, orthostatic hypotension, and memory deficit. A physician's order, dated 12/6/25, indicated to administer two (2) Rytary (an extended-release medication used to treat symptoms of Parkinson's disease) 61.25-245 milligram (mg) capsules three (3) times a day.A prescription order report sent to the pharmacy indicated the new electronic prescription order was sent successfully on 12/6/25 at 5:40 p.m.A physician's history and physical, dated 12/10/25, indicated the resident was admitted for rehabilitation and care after a fall related to the diagnosis of Parkinson's disease with dyskinesia. The plan was to continue the home dosing of Rytary 61.25-245 mg three (3) times a day. A current care plan, dated 12/16/25, indicated the resident was unable to independently perform activities of daily living related to Parkinson's disease, and required assistance with bed mobility, transfers, toileting and eating.A Medication Administration Record (MAR), dated December 2025, indicated the resident did not receive the ordered Rytary for Parkinson's disease due to the medication being unavailable on the following dates and times:On 12/14/25 at 6:00 a.m., 12:00 p.m., and 6:00 p.m. On 12/15/25 at 6:00 a.m., 12:00 p.m., and 6:00 p.m.On 12/16/25 at 6:00 a.m.A nursing progress note, dated 12/15/25 at 10:56 p.m., indicated the nurse had called the pharmacy to get a STAT (immediate) order of Rytary.A nursing progress note, dated 12/16/25 at 12:40 p.m., indicated Resident 116 reported dizziness and did not feel well. A nursing progress note, recorded as a late entry on 12/16/25 at 2:53 p.m., indicated the Assistant Director of Nursing (ADON) had been notified the resident did not have his Rytary. The medical record did not indicate the pharmacy was notified of the need for the Rytary until after the 6th missed dose. During an interview, on 12/16/25 at 1:49 p.m., the Assistant Director of Nursing (ADON) indicated she was not aware the resident missed several doses of his Parkinson's medication. She checked the medication cart and found 26 tabs in a box dated as delivered on 12/7/25. The box indicated it held 30 of 90 tablets. The ADON indicated the nurse would order medications when the medication was getting down to the last few doses. If the medication had run out, then staff would call the pharmacy and order a STAT (immediate) delivery of the medication.During an interview, on 12/16/25 at 3:27 p.m., the Director of Nursing (DON) indicated the pharmacy was aware of the need for the Parkinson's medication but had refused to make deliveries over the weekend due to the weather. During an interview, on 12/17/25 at 10:55 a.m., the facility's contracted pharmacist indicated the pharmacy had sent a 15-day supply of the medication on 12/7/25. The pharmacy then sent a refill out this week. The pharmacist indicated she did not see any medication order requests in their system from the facility other than the original 12/6/25 order which had been supplied on 12/7/25. The resident should have arrived with his medications from the previous facility which was a 14-day supply sent from the same pharmacy on 12/2/25. The resident should not have been out of his Parkinson's medication on 12/14/25. The pharmacy did not cancel any medication deliveries over the past week and had made deliveries every day the entire month of December. Even with severe weather, the pharmacy made deliveries, especially STAT (immediate) deliveries.During an interview, on 12/18/25 at 9:03 a.m., LPN 4 indicated routine medications were set to automatically refill. If a nurse noticed a medication was running low and the refill had not arrived, they would send a refill request in the electronic medical record. If the medication was completely out and not available in their floor stock, the nurse would call the pharmacy and request the medication immediately. The pharmacy would send the medication the same day, usually within a few hours. A pharmacy services agreement, dated 10/1/22 and provided by the DON on 12/16/25 at 3:15 p.m., indicated .agrees to deliver to the Facility (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any.prescriptions.daily, seven (7) days per week.with an additional delivery if an emergency arises.In the event the Pharmacy cannot furnish an ordered medication on a prompt and timely basis, the Pharmacy will make arrangements with another pharmacy supplier in the Facility's local community to provide such service(s) to the Facility at the Pharmacy's expense.A document, titled Full Prescribing Information, dated as revised 12/2019 and retrieved from https//rytaryhcp.com, indicated .Warnings and Precautions.Avoid sudden discontinuation or rapid dose reduction in patients taking RYTARY. If the decision is made to discontinue RYTARY, the dose should be tapered to reduce the risk of hyperpyrexia and confusion.Avoid sudden discontinuation or rapid dose reduction of RYTARY. 3.1-25(a)3.1-25(b)(3)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were labeled and dated and insulin was removed and discarded after 28 days in 2 of 4 medications carts reviewed for medication storage. (Ambassador Cart 1 and Heritage Cart 1)Findings include:1. During an observation, on [DATE] at 10:14 a.m., with LPN 2, the Heritage medication cart 1 had the following:a. One (1) Novolog insulin pen which was opened and not dated. There were 200 of 250 units left in the insulin pen.b. One (1) Basaglar insulin pen which was opened and dated [DATE].c. A bubble pack of Tramadol 50 milligrams (a controlled substance pain relieving medication) was found to have open packaging at the number two dose. During an interview, on [DATE] at 10:14 a.m., LPN 2 indicated the Novolog insulin should have had an open date. The Basaglar insulin pen was only good for 30 days. The Norco pill should have been removed and discarded. 2. During an observation, on [DATE] at 8:42 a.m., with LPN 3, the Ambassador medication cart 1 had the following:a. an Advair inhaler was in the drawer, not in a box, and was not labeled with a resident's name or a date to indicate when it had been opened. There were 98 doses left. The metal cannister inside the plastic was removed and was also found to not have a resident's name or an open date.b. a Fluticasone nasal spray bottle was found open (no seal), outside of the box, and did not have an open date or a resident's name on the bottle. During an interview, on [DATE] at 8:43 a.m., LPN 3 indicated the medications should have had a resident's name and dates on them.A current facility policy, titled DRUG STORAGE, undated and received from the Executive Director on [DATE] at 10:29 a.m., indicated .All expired, damaged and/or contaminated medications are removed from resident care areas and stored separately from medications available for administration .Insulin .injectable vials or pens must be discarded after 28 days 3.1-25(j)3.1-25(k)(1)