

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155841	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Copper Trace Health & Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>38872</p> <p>Based on interview and record review, the facility failed to ensure staff notified the responsible party/Power of Attorney (POA) of a resident's change in condition timely for 1 of 1 resident reviewed for notification. (Resident B)</p> <p>Finding includes:</p> <p>The clinical record for Resident B was reviewed on 12/5/24 at 9:12 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), emphysema, and vascular dementia.</p> <p>A nursing progress note, dated 6/7/24 at 1:57 p.m., indicated the resident had a change in condition to include a bad cough, trouble clearing her throat, and her oxygen saturation was 82 percent. The resident did refuse supplemental oxygen, but did eventually allow the oxygen. The resident needed to be fed, toileted, and was not waking up. The Nurse Practitioner was notified of the change in condition. There was no note to indicate the family had been notified at the time of the change in condition.</p> <p>A nursing progress note, dated 6/7/24 at 4:28 p.m., indicated the family was notified of the new orders.</p> <p>A nursing progress note, dated 6/7/24 at 4:59 p.m., indicated the resident was sent out to the hospital and the family was notified of the transfer.</p> <p>During an interview, on 12/5/24 at 9:38 a.m., the Director of Nursing indicated the family should have been contacted immediately for the change of condition.</p> <p>During a telephone interview, on 12/5/24 at 10:25 a.m., RN 3 indicated the resident had a change of condition on 6/7/24 at 1:57 p.m. The only reason she would not have documented contacting the family about the change in condition was if the Nurse Practitioner or the physician was going to notify the family. RN 3 indicated the facility policy was to notify the physician/nurse practitioner of the change and notify the responsible party/POA.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A current facility policy, titled Change in a Resident's Condition or Status, dated as last revised in April 2007 and received from the Director of Nursing on 12/6/24 at 12:30 p.m., indicated .Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status</p> <p>This citation relates to Complaint IN00444037.</p> <p>3.1-5(a)(2)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>38872</p> <p>Based on interview and record review, the facility failed to protect a resident from misappropriation of medication for 1 of 3 residents reviewed for misappropriation of property. (Resident C) The deficient practice was corrected on 11/22/24, prior to the start of the survey, and therefore was past noncompliance.</p> <p>Finding includes:</p> <p>During an interview, on 12/5/24 at 10:12 a.m., the Director of Nursing indicated the facility had not been aware of any missing items for Resident C, until an investigator from the Office of the Attorney General came to the facility to investigate the concern on 11/14/24. The investigator informed the facility during a domestic dispute, the local police entered the home of LPN 7, they saw the medication and reported the finding to the Office of the Attorney General (OAG). The facility found the prescription number was for Trulicity (a medication for diabetes), it belonged to Resident C and was filled by the resident's pharmacy. The facility began their own investigation of the incident and found the nurse had worked on the unit and had provided nursing care to Resident C prior to her termination. The nurse was terminated from employment on 6/16/24 for failure to report to her scheduled shift without notice.</p> <p>The clinical record for Resident C was reviewed on 12/5/24 at 1:38 p.m. The diagnoses included, but were not limited to, type 2 diabetes, dementia, and anxiety disorder.</p> <p>A physician's order for Trulicity injector pen 1.5 milligrams /0.5 milliliters was found in the orders.</p> <p>A current facility policy, titled Abuse, Neglect, and Misappropriation Prohibition and Prevention Policy, dated as last revised on 6/4/19 and received from the Director of Nursing on 12/6/24 at 12:50 p.m., indicated .It is the policy .to provide each resident with an environment that is free from .misappropriation of their property</p> <p>The deficient practice was corrected on 11/22/24 after the facility implemented a systemic plan that included the following actions: the facility investigated the incident involving Resident B, educated the staff on misappropriation of property and documentation in the Medication Administration Record. LPN 7 had been terminated prior to knowledge of the misappropriation of the insulin pen. The facility continued daily audits of medication disposal and medication disposal was to be completed with two (2) nurses.</p> <p>This citation relates to Complaint IN00447334.</p> <p>3.1-28(a)</p>		