

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/22/2025	
NAME OF PROVIDER OR SUPPLIER HERITAGE WOODS OF NOBLESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 9600 E 146TH STREET, NOBLESVILLE, , 46060					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00456733 and IN00456055. Complaint IN00456733 - State deficiencies related to the allegations are cited at R240. Complaint IN00456055 - No deficiencies related to the allegations are cited. Survey dates: April 21 and 22, 2025 Facility number: 014213 Residential Census: 122 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 28, 2025.	R 0000					
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d)	R 0240	1 What corrective action(s) will be accomplished for those			05/14/2025	

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(d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.

Based on record review and interview, the facility failed to implement fall interventions for a cognitively impaired resident (Resident C) that resulted in a fall with injury.

Findings include:

Resident C's clinical record was reviewed on 4/21/25 at 11:40 a.m. Diagnoses included arthritis, hypertension, severe obesity, subdural hematoma, type 2 diabetes mellitus uncontrolled, and vascular dementia.

A current service plan, dated 3/14/25, indicated the resident was at risk for falls. Wellness checks were to be provided in accordance with the Wellness Check Policy.

A "Memory Care CNA Assignment Sheet", dated 2/5/25, indicated the resident was to have wellness checks at night.

A progress noted, dated 3/19/25 at 6:03 a.m., indicated LPN 1 walked onto the unit and heard a scream for help. The resident was found sitting on the floor. There was dried blood on the floor and the resident had a bloody hematoma (bruise) to the

residents found to have been affected by the deficient practice;

a 2

How

the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

a All residents had the potential to be affected by the alleged deficient practice.

DON and/or designee will in-service clinical staff on completing daily wellness checks. DON and/or designee will audit CNA assignment sheets and/or assigned tasks in the electronic medical record to ensure completion of daily wellness checks. Employees found to be out of compliance with wellness check documentation will receive additional education and corrective action.

back of the head. 911 was called and family was notified.

A progress note, dated 3/19/25 at 6:15 a.m., the following: "Reporting Transition Out on March 19, 2025 at 7:15 a.m., to Hospital/ER. Reason(s): Fall."

A hospital "Rehab Care Program" note, dated 3/28/25, indicated a diagnosis of subdural hematoma with residual balance dysfunction and worsening cognitive function.

During the survey, the resident remained an inpatient at the rehab hospital.

During an interview on 4/22/25 9:42 a.m., LPN 1 indicated she arrived to the facility and entered through the memory care unit entrance. She heard someone yelling for help and started searching for where the yelling was coming from. After locating where the yelling was coming from, LPN 1 and LPN 3 entered the resident's room. The resident was in the kitchenette on the floor, sitting on her bottom. She was wearing a night gown, brief, and non-skid socks. She complained of her head hurting. LPN 1 left to call 911 while LPN 3 stayed with the resident and called her family. There was dried blood on the floor. The resident had blood on her hands, arms, and

3

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;

a All clinical staff will be re-educated and in-serviced on completing daily wellness checks. Any clinical staff member out of compliance with facility's policies and protocols will receive progressive corrective action, including termination. The Director of Nursing, or designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols during employee job-specific orientation moving forward.

4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;

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the back of her head. There was a good amount of blood. QMA 2 had been assigned to care for the resident during the prior night shift.

During an interview on 4/22/25 at 10:18 a.m., LPN 3 indicated she arrived to the facility at approximately 7:00 a.m. through the memory care entrance. She and LPN 1 heard someone yelling. The resident was found sitting on the floor of the kitchenette area. She had her legs in front of her. She clearly had hit her head. The resident had blood on her hands and was crying. 911 and her family were called. When the paramedics came, they asked her how she fell and she could not remember.

During an interview on 4/22/25 at 10:41 a.m., the Administrator indicated no one went into the resident's room on the third shift. The Administrator indicated she watched the entire video for that shift (third shift) and people walked past it but no one went into the room.

During an interview on 4/22/25 at 10:45 a.m., QMA 2 indicated the resident was on her assignment at the time of her fall. QMA 2 indicated resident was not on 2-hour checks nor wellness checks. the unit used CNA assignment sheets. QMA 2 indicated she did not go to her

a This process will be reviewed by DON/ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process.

b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved.

5
By
what date the systemic
changes will be completed;

a May 14, 2025

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room during the shift because the resident was independent and did everything for herself.

During an interview on 4/22/25 at 11:00 a.m., the Administrator and DON indicated staff should have followed the CNA assignment sheet and provided the wellness check on the night shift. The wellness check is an eyes-on assessment. Staff needed to see the resident and ensure their well being.

A current facility policy, dated 7/2019, titled "Daily Wellness Check" was provided by the DON on 4/22/25 at 12:56 p.m. The policy indicated he following:

" PURPOSE: The purpose of this policy is to ensure that the system to check on the welfare of each resident daily is implemented.

POLICY: It is the policy of this community to perform a daily welfare check on each resident in order to provide a safe and reassuring environment for each resident.

RESPONSIBILITY:

A. It is the responsibility of the C.N.A. to check on each Resident, by visually laying eyes on them at least once daily."

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This citation relates to complaint IN00456733.

Based on record review and interview, the facility failed to implement fall interventions for a cognitively impaired resident (Resident C) that resulted in a fall with injury.

Findings include:

Resident C's clinical record was reviewed on 4/21/25 at 11:40 a.m. Diagnoses included arthritis, hypertension, severe obesity, subdural hematoma, type 2 diabetes mellitus uncontrolled, and vascular dementia.

A current service plan, dated 3/14/25, indicated the resident was at risk for falls. Wellness checks were to be provided in accordance with the Wellness Check Policy.

A "Memory Care CNA Assignment Sheet", dated 2/5/25, indicated the resident was to have wellness checks at night.

A progress noted, dated 3/19/25 at 6:03 a.m., indicated LPN 1 walked onto the unit and heard a scream for help. The resident was found sitting on the floor. There was dried blood on the floor and the resident had a bloody hematoma (bruise) to the back of the head. 911 was called and family was notified.

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During the survey, the resident remained an inpatient at the rehab hospital.

During an interview on 4/22/25 9:42 a.m., LPN 1 indicated she arrived to the facility and entered through the memory care unit entrance. She heard someone yelling for help and started searching for where the yelling was coming from. After locating where the yelling was coming from, LPN 1 and LPN 3 entered the resident's room. The resident was in the kitchenette on the floor, sitting on her bottom. She was wearing

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a night gown, brief, and non-skid socks. She complained of her head hurting. LPN 1 left to call 911 while LPN 3 stayed with the resident and called her family. There was dried blood on the floor. The resident had blood on her hands, arms, and the back of her head. There was a good amount of blood. QMA 2 had been assigned to care for the resident during the prior night shift.

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During an interview on 4/22/25 at 11:00 a.m., the Administrator and DON indicated staff should have followed the CNA assignment sheet and provided the wellness check on the night shift. The wellness check is an eyes-on assessment. Staff needed to see the resident and ensure their well being.

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This citation relates to complaint IN00456733.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR
PROVIDER/SUPPLIER REPRESENTATIVE'S
SIGNATURE

TITLE

(X6) DATE