STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE WOODS OF NOBLESVILLE	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 a Post Survey Revisit (PSR) to the Investigation of Complaint IN00351557 completed on 4/20/21. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaints IN00353102 and IN00354013 completed on 6/1/21. This visit was in conjunction with a PSR to the Investigation of Complaint IN00360659 completed on 8/24/21 This visit was in conjunction with a PSR to unrelated findings writen during the Investigation of Complaints IN00356573, IN00357154, and IN00356217 completed on 7/12/21. This visit was in conjunction with a PSR to unrelated findings writen during the nvestigation of Complaint IN00358589 completed on 8/3/21.	R 0000	Disclaimer: The submission of this plan of correction does not indicate an admission by Heritage Woods of Noblesville that the findings and allegations contained herein are accurate , true representation of the quality of care provided and living environment provided to the residents of Heritage Woods of Noblesville. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirement of participation for Assisted Living Facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	

	This visit was in conjunction with the Investigation of Complaint IN00361476. This visit included a COVID-19 Quality Assurance Walk-through. Complaint IN00351557- Not corrected. Survey dates: October 4, 5 and 6, 2021 Facility number: 014213 Residential Census: 121 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 14, 2021. This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00351557 completed on 4/20/21. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaints IN00353102 and IN00354013 completed on 6/1/21. This visit was in conjunction with a PSR to the Investigation of Complaint IN00360659 completed on 8/24/21 This visit was in conjunction with a PSR to unrelated findings writen during the Investigation of Complaints IN00356573,			

	IN00357154, and IN00356217 completed on 7/12/21. This visit was in conjunction with a PSR to unrelated findings writen during the nvestigation of Complaint IN00358589 completed on 8/3/21. This visit was in conjunction with the Investigation of Complaint IN00361476. This visit included a COVID-19 Quality Assurance Walk-through. Complaint IN00351557- Not corrected. Survey dates: October 4, 5 and 6, 2021 Facility number: 014213 Residential Census: 121 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 14, 2021.			
R 0041	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(o)(4) (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident;	R 0041		

	(B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals. Based and interview and record review the facility failed to resolve resident grievances regarding long call light waits and meal services for 5 of 5 residents interviewed (Residents B, C, D, E, and M). Findings include: Minutes from the 8/26/21, Resident Council Meeting indicated the following: "Residents said it takes up to 50 minutes for CNAs and QMAs to respond to call buttons." The facility response documented beside the concern was, "Staff are monitoring call light times." During a 10/5/21, 9:51 a,m, interview, Resident D indicated call light waits are often 50 minutes in length. The resident indicated this happens two times a week or more. The resident also indicated this was an on ongoing problem and the facility leadership was aware and had not corrected the problem.			

	During a 10/5/21, 10:20 a.m., interview, Resident B indicated there were lengthy waits for meal service. The resident indicated sometimes residents left the dining room and ate snacks they had in their room instead. The resident also indicated sometimes residents assist in the dining room to try to help out. The resident indicated this was an ongoing problem and the facility leadership was aware and had yet to correct the issues. During a 10/5/21, 10:48 a.m., interview, Resident C indicated the facility had an ongoing problem with lengthy meal waits and long call light waits. The resident also indicated residents often help with meal service to reduce the long wait. The resident indicated these concerns were expressed in resident council on a regular basis without a successful solution. During a 10/5/21, 1:06 p.m. interview, Resident E indicated the meal waits are often times very long and sometimes the residents assist with meal service. Recently the residents waited 42 minutes for the meal to be served. The resident indicated other residents often times got upset and left before the meal was served. The resident indicated the facility leadership was aware and had			

	yet to solve the problem. The resident indicated residents have been complaining about long call light waits for a long time as well and this issue had also not been solved During a 10/6/21, 1:50 a.m., interview, Resident M indicated the facility took so long to serve meals that residents got upset and left the dining room. The resident indicated the facility leadership were aware of this concern. The resident also indicated residents continue to complain of long call light waits and it has not been corrected. The resident indicated these repeated concerns where stated in resident council for many months. During a 10/5/21, 10:03 a.m. interview, the Administrator indicated the facility had a method to monitor call lights and print off a report with response time. She indicated the report was an internal report and not shared. The facility failed to implement a systemic plan of correction to the state finding sited on 4/20/21. Based and interview and record review the facility failed to resolve resident grievances regarding long call light waits and meal services for 5 of 5 residents interviewed			

	(Residents B, C, D, E, and M). Findings include: Minutes from the 8/26/21, Resident Council Meeting indicated the following: "Residents said it takes up to 50 minutes for CNAs and QMAs to respond to call buttons." The facility response documented beside the concern was, "Staff are monitoring call light times." During a 10/5/21, 9:51 a,m, interview, Resident D indicated call light waits are often 50 minutes in length. The resident indicated this happens two times a week or more. The resident also indicated this was an on ongoing problem and the facility leadership was aware and had not corrected the problem.			

	During a 10/5/21, 10:20 a.m., interview, Resident B indicated there were lengthy waits for meal service. The resident indicated sometimes residents left the dining room and ate snacks they had in their room instead. The resident also indicated sometimes residents assist in the dining room to try to help out. The resident indicated this was an ongoing problem and the facility leadership was aware and had yet to correct the issues. During a 10/5/21, 10:48 a.m., interview, Resident C indicated the facility had an ongoing problem with lengthy meal waits and long call light waits. The resident also indicated residents often help with meal service to reduce the long wait. The resident indicated these concerns were expressed in resident council on a regular basis without a successful solution. During a 10/5/21, 1:06 p.m. interview, Resident E indicated the meal waits are often times very long and sometimes the residents assist with meal service. Recently the residents waited 42 minutes for the meal to be served. The resident indicated other residents often times got upset and left before the meal was served. The resident indicated the facility leadership was aware and had			

	yet to solve the problem. The resident indicated residents have been complaining about long call light waits for a long time as well and this issue had also not been solved During a 10/6/21, 1:50 a.m., interview, Resident M indicated the facility took so long to serve meals that residents got upset and left the dining room. The resident indicated the facility leadership were aware of this concern. The resident also indicated residents continue to complain of long call light waits and it has not been corrected. The resident indicated these repeated concerns where stated in resident council for many months. During a 10/5/21, 10:03 a.m. interview, the Administrator indicated the facility had a method to monitor call lights and print off a report with response time. She indicated the report was an internal report and not shared. The facility failed to implement a systemic plan of correction to the state finding sited on 4/20/21.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from:	R 0052		

(1) sexual abuse;

(2) physical abuse;

(3) mental abuse;

(4) corporal punishment;

(5) neglect; and

(6) involuntary seclusion.

Based on observation, interview, and record review the facility failed to ensure a resident with dementia received supervision to prevent elopement for 1 of 1 residents reviewed for elopement (Resident F) resulting in the resident being unsupervised outside the facility for an unknown period of time.

Findings Include:

A 9/30/2021, facility self reported incident report indicated the following:

"Brief Description of Incident:

...9/30/21 Door alarms sounded briefly and staff responded to check all memory care doors. During a head count of all residents, ambulatory memory care resident was noted outside the service entrance doors sitting in the dietary mangers car."

A 9/29/2021, written statement by QMA 1 regarding the 9/29/21

resident elopement event indicated the following:

"... I received a call from kitchen manager asking me to come to the parking area through the back door there is a resident in his car, I immediately ran out outside (sic) and I found resident sitting in the passenger seat of [dietary manager's name] car and the nurse was standing beside the car trying to get the resident from the car. The resident was [too] tired and weak to get herself from the car. So I tried to help her but I couldn't make it because the car seat was to (sic) low. So I asked [the dietary manager's name] to help me get her from the car and [with] both of us we managed [to] get her out and immediately the resident started crying. We both took resident back to the memory care unit."

A 9/29/2021, written statement by the Dietary Manager regarding the 9/29/21 resident elopement event indicated the following:

"After clocking out on 9/29/21 at 7:15 I walked out the door and noticed someone sitting in the passenger seat of my car. It was a resident of White Oaks [the memory care unit]. I came back into the building to get [the cook's name], my evening cook, from the break room. I asked [the cook] to go to White Oaks

and get the nurse [name] as I kept on eye on [Resident F's name] making sure she didn't leave. ...but needed my assistance to lift [resident's name] out as the car was parked on an incline. ...At that point we tried to figure out what happened and how she got out of White Oaks..."

A 9/29/2021, written statement by LPN 8 regarding the 9/29/21 resident elopement event indicated the following:

"I was at the [nursing] office checking off medication I had just given when the door alarm went off. [C.N.A. 10] went to the south side of the building. I went to the north side. While making head count I [specifically] asked the family in [room number] that was (sic) moving out furniture through the loading door if they set off the alarms. They said 'no'. Then the cook came in and said 'she in car' (sic). Went out loading dock door and the kitchen manager was standing at the door. I seen pt [patient] in the passenger side of his car..."

A 9/29/2021, written statement by Cook 7 regarding the 9/29/21 resident elopement event indicated the following:

" [Dietary Manger] came to the break room and asked me to go get the nurse from memory care because one of the residents

was sitting in his car. He showed me then I went to get the nurse and took her outside to get the resident. ...[The Dietary Manager] and [QMA] got the resident out of the car and took her back to Memory Care,"

A 9/29/2021, written statement by CNA 4 regarding the 9/29/21 resident elopement event indicated the following:

"I was sitting [at] CNA station when another aid ran down and asked did we hear the alarm. I stated no this is my first time here so I was clueless to what the alarm ment (sic)."

Resident F's clinical record was reviewed on 10/4/21. The resident's current diagnosis included, but were not limited to, dementia, anxiety, depression, and macular degeneration. The resident resided on a secured, locked, dementia unit.

A 9/30/21, 2:15 p.m., Note which indicated "Late Entry for 9/29/21...at approx [approximately] 7pm nurse heard the door alarm sounding--quickly the C.N.A. came to the nurse and stated she had checked the hallways outside the unit and all the doors--nurse began a head count on unit--at the time nurse entered Pt's [patients] apt [apartment] the cook from the kitchen came to nurse and said

[the resident is] 'in car' -- nurse followed her and went to loading dock and Pt was sitting in the kitchen managers' car..."

During an interview on 10/4/21 at 2:00 p.m., the Administrator indicated Resident F exited the facility the evening of 9/29/21. She indicated the facility could not determine how the resident exited the facility or what time she left. The Administrator indicated the resident did eat dinner in the dining area with the other residents the night of 9/29/21. She indicated although an alarm sounded, the facility was unable to determine which door alarm had sounded. She indicated she did not know why the staff could not differentiate which alarm had sounded. She indicated the facility had reviewed the video surveillance of the 2 main doors and could not see the resident exiting the facility. The Administrator indicated a family had been moving furniture in and out of the service/loading dock door around the day the resident exited the facility. She indicated the resident was not seen on the video surveillance exiting the facility after the family disposed of furniture, The family was interviewed and did not believe they had let anyone out nor did they see any resident in the hallway when they took furniture out the service entrance/loading dock doors. In

additional, the facility did not know how long the resident was outside.

During an observation on 10/4/21 at 3:41 p.m., the entrance to the memory care unit had alarms on the exit to the assisted living area of the facility and the service hallway. The exit to the service hallway had the keypad door alarm which remained unlocked for several seconds after the door was opened. The exit door leading to the assisted living area of the build latched the door again very quickly.

During an observation on 10/4/21 at 3:56 p.m., Resident F was walking independently in the memory care unit of the facility.

During an observation with the Administrator on 10/5/21 at 8:48 a.m., the secure door which enters the memory care unit was tested and the alarm sounded. The other alarms on the unit did not sound. During an interview on 10/5/21 at 8:48 a.m., the Administrator indicated the door had functioned correctly and all door alarms do not sound when one alarm is activated.

The facility failed to implement a systemic plan of correction to the state finding sited on 8/24/21.

Based on observation, interview, and record review the facility failed to ensure a resident with dementia received supervision to prevent elopement for 1 of 1 residents reviewed for elopement (Resident F) resulting in the resident being unsupervised outside the facility for an unknown period of time.

Findings Include:

A 9/30/2021, facility self reported incident report indicated the following:

"Brief Description of Incident:

...9/30/21 Door alarms sounded briefly and staff responded to check all memory care doors. During a head count of all residents, ambulatory memory care resident was noted outside the service entrance doors sitting in the dietary mangers car."

A 9/29/2021, written statement by QMA 1 regarding the 9/29/21 resident elopement event indicated the following:

"... I received a call from kitchen manager asking me to come to the parking area through the back door there is a resident in his car, I immediately ran out outside (sic) and I found resident sitting in the passenger seat of [dietary manager's name] car and the nurse was

standing beside the car trying to get the resident from the car. The resident was [too] tired and weak to get herself from the car. So I tried to help her but I couldn't make it because the car seat was to (sic) low. So I asked [the dietary manager's name] to help me get her from the car and [with] both of us we managed [to] get her out and immediately the resident started crying. We both took resident back to the memory care unit."

A 9/29/2021, written statement by the Dietary Manager regarding the 9/29/21 resident elopement event indicated the following:

"After clocking out on 9/29/21 at 7:15 I walked out the door and noticed someone sitting in the passenger seat of my car. It was a resident of White Oaks [the memory care unit]. I came back into the building to get [the cook's name], my evening cook, from the break room. I asked [the cook] to go to White Oaks and get the nurse [name] as I kept on eye on [Resident F's name] making sure she didn't leave. ...but needed my assistance to lift [resident's name] out as the car was parked on an incline. ...At that point we tried to figure out what happened and how she got out of White Oaks..."

A 9/29/2021, written statement

by LPN 8 regarding the 9/29/21 resident elopement event indicated the following:

"I was at the [nursing] office checking off medication I had just given when the door alarm went off. [C.N.A. 10] went to the south side of the building. I went to the north side. While making head count I [specifically] asked the family in [room number] that was (sic) moving out furniture through the loading door if they set off the alarms. They said 'no'. Then the cook came in and said 'she in car' (sic). Went out loading dock door and the kitchen manager was standing at the door. I seen pt [patient] in the passenger side of his car..."

A 9/29/2021, written statement by Cook 7 regarding the 9/29/21 resident elopement event indicated the following:

" [Dietary Manger] came to the break room and asked me to go get the nurse from memory care because one of the residents was sitting in his car. He showed me then I went to get the nurse and took her outside to get the resident. ...[The Dietary Manager] and [QMA] got the resident out of the car and took her back to Memory Care,"

A 9/29/2021, written statement by CNA 4 regarding the 9/29/21 resident elopement event indicated the following:

"I was sitting [at] CNA station when another aid ran down and asked did we hear the alarm. I stated no this is my first time here so I was clueless to what the alarm ment (sic)."

Resident F's clinical record was reviewed on 10/4/21. The resident's current diagnosis included, but were not limited to, dementia, anxiety, depression, and macular degeneration. The resident resided on a secured, locked, dementia unit.

A 9/30/21, 2:15 p.m., Note which indicated "Late Entry for 9/29/21...at approx [approximately] 7pm nurse heard the door alarm sounding--quickly the C.N.A. came to the nurse and stated she had checked the hallways outside the unit and all the doors--nurse began a head count on unit--at the time nurse entered Pt's [patients] apt [apartment] the cook from the kitchen came to nurse and said [the resident is] 'in car' -- nurse followed her and went to loading dock and Pt was sitting in the kitchen managers' car..."

During an interview on 10/4/21 at 2:00 p.m., the Administrator indicated Resident F exited the facility the evening of 9/29/21. She indicated the facility could not determine how the resident exited the facility or what time she left. The Administrator

indicated the resident did eat dinner in the dining area with the other residents the night of 9/29/21. She indicated although an alarm sounded, the facility was unable to determine which door alarm had sounded. She indicated she did not know why the staff could not differentiate which alarm had sounded. She indicated the facility had reviewed the video surveillance of the 2 main doors and could not see the resident exiting the facility. The Administrator indicated a family had been moving furniture in and out of the service/loading dock door around the day the resident exited the facility. She indicated the resident was not seen on the video surveillance exiting the facility after the family disposed of furniture, The family was interviewed and did not believe they had let anyone out nor did they see any resident in the hallway when they took furniture out the service entrance/loading dock doors. In additional, the facility did not know how long the resident was outside.

During an observation on 10/4/21 at 3:41 p.m., the entrance to the memory care unit had alarms on the exit to the assisted living area of the facility and the service hallway. The exit to the service hallway had the keypad door alarm which remained unlocked for

	several seconds after the door was opened. The exit door leading to the assisted living area of the build latched the door again very quickly. During an observation on 10/4/21 at 3:56 p.m., Resident F was walking independently in the memory care unit of the facility. During an observation with the Administrator on 10/5/21 at 8:48 a.m., the secure door which enters the memory care unit was tested and the alarm sounded. The other alarms on the unit did not sound. During an interview on 10/5/21 at 8:48 a.m., the Administrator indicated the door had functioned correctly and all door alarms do not sound when one alarm is activated. The facility failed to implement a systemic plan of correction to the state finding sited on 8/24/21.				

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