STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/20/2022

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 the Investigation of Complaints IN00391451, IN00390553 and IN00391791. Complaint IN00391451 - Substantiated. No State Residential Findings related to the allegations were cited. Complaint IN00390553 - Substantiated. No State Residential Findings related to the allegations were cited. Complaint IN00391791 - Substantiated. State Residential Findings related to the allegations are cited at R0060. Survey date: October 19 and 20, 2022 Facility number: 014213 Residential Census: 108 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.	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 substantial compliance.	

	Quality review completed October 21, 2022			
R 0060	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(dd) (dd) The facility shall provide reasonable access to any resident, consistent with facility policy, by any entity or individual that provides health, social, legal, and other services to any resident, subject to the resident ' s right to deny or withdraw consent at any time. Based on record review, observation and interview the facility failed to provide adequate supervision to prevent the elopement from the facility of a cognitively impaired resident (Resident B). Findings include: The clinical record for Resident B was reviewed on 10/19/2022 at 10:50 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, depressive disorder and anxiety disorder. Review of the "Level of Service Assessment/Evaluation", dated 7/20/2022, indicated Resident B had a safety concern related to severely impaired decision making, disorientation that resulted in not being able to function independently and	R 0060	The corrective action that will be accomplished for the resident found to be affected by the alleged deficient practice; Resident B had no negative affects related to alleged deficient practice. The measures put in place and systematic changes the facility will make to ensure that the alleged deficient practice does not recur. A). Resident identified as appropriate for Memory Care and has been transferred. B). Door will remain locked between the hours of 8:00pm and 8:00am. Independent resident has been inserviced and has shown ability to lock and unlock the entrance door. C.) Staff has been assigned a different entrance to utilize during the hours of 8:00pm-8:00am to report for shift change. Update amendment A). Resident B identified as appropriate for Memory Care has been transferred. Resident B had no negative affects related to alleged deficient practice. B.) Any other resident with cognitive deficits could be affected of alleged deficient practice. C). Inservice by the DON will take place on 11/23/2022 to evening and night shift supervisors (LPN/QMA). Staff will be	11/11/2022

constant confusion.

On 10/19/2022 at 9:57 a.m., a security video for 10/1/2022 was reviewed with the Maintenance Director. Resident B was seen ambulating through the main lobby and out of the front doors at 6:51 a.m. At 6:53 a.m., a staff member was seen walking the resident back into the facility. The Maintenance Director indicated the front doors are locked at 8:00 p.m. and unlocked at 8:00 a.m. The Maintenance Director did not know why the doors were not locked.

During an interview on 10/20/2022 at 8:49 a.m., the Administrator indicated the front door was left unlocked by another resident at approximately 5:30 a.m. This resident was independent and who lets himself out to smoke. The resident failed to lock the door after returning to the facility. The staff member observed returning the resident to the facility was unavailable for interview. The resident was immediately moved to the secured Memory Care unit.

During an interview on 10/20 /2022 at 9:37 a.m., the Marketing Director indicated upon admission the family for Resident B had requested the resident be put on a waiting list for the secured Memory Care

responsible for ensuring the doors are locked by 8pm and will check at 9:30pm, 1:00am, and 4:00am that doors remain locked. The 24 hours report sheet updated to include door monitoring checks at stated times. This monitoring will be on-going. The Director of Nursing will audit 24 hours report for nursing physical checks weekly x 2 months then monthly x 4 months. Smokers educated to use other outdoor area within grounds of community all times of the day/night. DON/designee will complete SLUMs pre-admit, annually and change in cognition. Administrator/designee will audit weekly x 8 weeks then monthly x 6 months for completion of SLUMs as well add resident to acuity/watch list to determine safe placement Administrator will audit watch list weekly x 8 weeks then monthly x 6 months. B) Monthly elopement drills will be implemented.

D). The measures put in place and systemic changes the facility will make to ensure that the alleged deficient practice does not recur: A) DON or designee will audit clinical documentation daily for residents actively exit seeking, address with physician and plan will be developed for resident with immediate safety. Monthly QA committee will review all audits, door lock audit and elopement drills x 6 months. QA criteria will be zero new elopements and doors locked 100% and all residents needing Memory Care will transfer within 15 days of determination as well as make recommendations for need of on-going audits.

unit for safety.

This residential tag relates to complaint IN00391791.

Based on record review, observation and interview the facility failed to provide adequate supervision to prevent the elopement from the facility of a cognitively impaired resident (Resident B).

Findings include:

The clinical record for Resident B was reviewed on 10/19/2022 at 10:50 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, depressive disorder and anxiety disorder.

Review of the "Level of Service Assessment/Evaluation", dated 7/20/2022, indicated Resident B had a safety concern related to severely impaired decision making, disorientation that resulted in not being able to function independently and constant confusion.

On 10/19/2022 at 9:57 a.m., a security video for 10/1/2022 was reviewed with the Maintenance Director. Resident B was seen ambulating through the main lobby and out of the front doors at 6:51 a.m. At 6:53 a.m., a staff member was seen walking the resident back into the facility. The Maintenance Director indicated the front doors are

	locked at 8:00 p.m. and unlocked at 8:00 a.m. The Maintenance Director did not know why the doors were not locked. During an interview on 10/20/2022 at 8:49 a.m., the Administrator indicated the front door was left unlocked by another resident at approximately 5:30 a.m. This resident was independent and who lets himself out to smoke. The resident failed to lock the door after returning to the facility. The staff member observed returning the resident to the facility was unavailable for interview. The resident was immediately moved to the secured Memory Care unit. During an interview on 10/20 /2022 at 9:37 a.m., the Marketing Director indicated upon admission the family for Resident B had requested the resident be put on a waiting list for the secured Memory Care unit for safety. This residential tag relates to complaint IN00391791.			

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