

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 07/31/2024
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 Complaint IN00438221. Complaint IN00438221 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey date: July 30 and 31, 2024 Facility number: 014213 Residential Census: 123 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed August 1, 2024.	R 0000			
R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect,	R 0029	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement of	08/20/2024	

and recognition of their dignity and individuality.

Based on record review and interview, the facility failed to ensure residents were treated with dignity and respect by staff during care for 1 of 3 residents reviewed for abuse. (Resident C)

Findings include:

During an interview on 7/30/24 at 2:18 p.m., the Administrator indicated she was notified by a staff member of an abuse allegation by Resident C's family. She planned to start employee interviews, resident assessments, and was currently waiting on the family to return her call for more information. She attempted to contact the named employee, but was unsuccessful.

A 7/30/24, facility self-reported incident indicated the Director of Nursing (DON) had been notified that family of Resident C had posted an allegation of abuse to the facility's electronic medical record communication portal. The immediate actions taken included ensuring the safety of the resident and the employee in question, identified as HHA 3, was suspended pending investigation. Preventative measures taken included skin assessments for all residents on the Memory

this facility of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/ or executed in compliance with State and Federal laws.

The facility is requesting paper compliance for all deficiencies in this POC.

R029 Residents Rights

1. The corrective action that will be accomplished for those residents found to have been affected by the alleged deficient practice:

Administrator met with Resident C family to discuss Resident Right to be treated with consideration, respect and recognition of their dignity and individuality and apologize for any concerns related to such. Family voiced confidence in the actions of the community leadership and feels like family member is in the appropriate level of care at this time.

2. How the facility will identify other residents having the potential to be affected by the alleged

Care unit, 72- hour psychosocial monitoring initiated, and review of service plans.

Resident C's clinical record was reviewed on 7/30/24 at 4:00 p.m. Current diagnosis included dementia in other diseases classified elsewhere, anxiety, age-related cognitive decline, and age-related physical debility.

A current "Level of Service Assessment", dated 5/20/24, indicated Resident C was constantly confused or disoriented and decision making was severely limited. This resident was dependent on staff for dressing, undressing, toileting, personal hygiene, and bathing.

A 3/12/24, Saint Louis University Mental Status (SLUMS) assessment tool (a tool to quickly assess cognitive functions) scored Resident C as 0 out of 30. This scoring tool indicated the outcome as dementia.

A review of the facility investigation file, provided by the Administrator, on 7/31/24 at 10:11 a.m., indicated the following:

A 7/30/24, written statement from the Memory Care Director indicated Resident C's representative came to the facility on 7/30/24 at 11:15 a.m.

**deficient practice
and the corrective action that
will be taken:**

All memory care assisted living residents had potential to be affected. In-Service all staff on Resident Rights August 2, 2024. Any staff who fail to comply with the points of the in-service will be further educated and progressively disciplined as indicated. Administrator or designee will connect with all memory care assisted living resident's representative to determine if any other residents have had rights or dignity concerns.

**3. The measures put in place
and systemic
changes the facility will make
to ensure that the alleged
deficient practice
does not recur:**

Director of Nursing or designee will continue to routinely monitor the communication log of any documentation indicating psycho social distress. Director of Nursing or designee will continue to routinely monitor memory care resident shower sheets for any area of concern. Administrator or designee will continue to provide quarterly education to

and showed her a video, via the electronic medical record communication portal. In the video, HHA 3 was talking with CNA 4 about the resident's family, and being rough with the resident. The Memory Care Director reported these concerns to the DON immediately.

Two 7/30/24, " Heritage Woods & White Oaks Witness Statement" interviews were completed by the Administrator over the phone, with Resident C's family. The family indicated they understood the resident could be difficult, but HHA 3 was rough with her treatment of Resident C and should have had more patience.

A 7/31/24, " Heritage Woods & White Oaks Witness Statement" interview was completed by the Administrator with CNA 4. CNA 4 indicated she had no concerns with HHA 3's work on the day in question, but Resident C could be combative with care. This employee was aware of the cameras in Resident C's room.

Review of the video footage with the Administrator, on 7/31/24 at 12:30 p.m., showed Resident C lying in bed with her head on a pillow and a blanket covering her. Two staff members were present at the bedside. HHA 3 could be heard talking to CNA 4

include communication and proper care technique when working with residents that have dementia or other cognitive impairment.

4. The corrective action will be monitored to ensure the alleged deficient practice will not recur: As a measure of ongoing compliance, the monthly QA committee will review the following:

The Director of Nursing or designee audit of the memory care resident shower sheets daily for 1 week, weekly for 3 weeks, bi-weekly for 3 months, monthly for 2 months, and continue with the standard practice thereafter; the Administrator or designee will follow up with 2 staff members and 2 family members to ensure there are no concerns in regards to residents rights or dignity daily for 1 week, weekly for 3 weeks, bi-weekly for 3 months, monthly for 2 months.

5. The date the system changes will be completed:

August 20, 2024

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saying "... other residents in this room, she is the one going into other residents room, that don't make no sense". HHA 3 flipped Resident C's blanket off her without warning. Resident C attempted to roll over and grab the blanket, but HHA 3 was heard saying "... naw, naw, negative, negative... standing up, baby... you know better" and moved the blanket farther out of the reach of Resident C. Next, HHA 3 grabbed both of Resident C's legs at the calf area and pulled them towards the edge of the bed, causing the resident's head to slide off the pillow.

During a interview, at the time of the video footage review, the Administrator indicated the employee's behavior was inappropriate. She had not been able to contact HHA 3.

A review of HHA 3's employee file, on 7/31/24 at 12:42 p.m., indicated her hire date was 1/30/24. A 1/29/24, "Resident Rights" document was acknowledged and signed by HHA 3.

A 7/31/24 education transcript of completed courses indicated HHA 3 completed the following dementia trainings: "Dementia care: CMS Hand in Hand Module 1: Understanding the World of Dementia: The Person and Disease", completed

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2/1/24. "Dementia care: CMS Hand in Hand Module 2: Being with a Person with Dementia: Listening and Speaking", completed 2/1/24. "Dementia care: Normal Aging vs Alzheimer's/Dementia", completed 2/1/24.

A current facility policy, last approved 1/22, titled, "Resident's Personal Rights Policy and Procedure", provided by the DON, on 7/31/24 at 1:12 p.m., indicated the following: "...14. Be treated at all times with courtesy, respect, and full recognition of personal dignity and individuality...."

Based on record review and interview, the facility failed to ensure residents were treated with dignity and respect by staff during care for 1 of 3 residents reviewed for abuse. (Resident C)

Findings include:

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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
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