STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/15/2022

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 Complaint IN00369959, IN00372330 and IN00372386. Complaint IN00369959 - Substantiated. State deficiencies related to the allegations are cited at R0090 and R0217. Complaint IN00372330 - Substantiated. State deficiencies related to the allegations are cited at R0059 and R0217. Complaint IN00372386 - Substantiated. State deficiencies related to the allegations are cited at R0059, R0090 and R0217. Survey dates: February 14 and 15, 2022 Facility number: 014213 Residential Census: 120 These State Residential	R 0000	**Disclaimer: The submission of this plan correction does not indicate an admission by Heritage Woods of Noblesville that the findings and allegations contained herein are an 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 requirements 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 statue only. The facility**	

	Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 17, 2022.		**respectfully requests from the department a desk review for substantial compliance.**	
R 0059	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(cc) (cc) Residents have the right to choose with whom they associate. The facility shall provide reasonable visiting hours, which should include at least twelve (12) hours a day, and the hours shall be made available to each resident. Policies shall also provide for emergency visitation at other hours. The facility shall not restrict visits from the resident ' s legal representative or spiritual advisor, except at the request of the resident. Based on interview and record review, the facility failed to provide reasonable visitation for 2 of 3 residents reviewed for rights. (Resident B and F). Findings include: During an observation on 2/14/22 at 2:48 p.m., after several minutes of ringing the doorbell to gain entry into the Memory Care Unit, CNA 1 and CNA 2 were observed in the work station on their personal phones. CNA 1 indicated she was about to leave so she was on her cell phone and did not	R 0059	**R 059** • The corrective action that will be accomplished for those residents found to have been affected by the alleged deficient practice; Visitation hours were posted at the front entrance of the community, along with the number to call for after-hours access, a missing doorbell chime was replaced on 2-15 and prompts added to the phones for nursing offices extensions. • How the facility will identify other residents having the potential to be affected by the alleged deficient practice and the corrective action that will be taken; A) No MC residents were affected by alleged deficient practice. • The measures put in place and systemic changes the facility will make	03/17/2022

	hear the doorbell. 1. During a telephone interview on 2/14/22 at 12:55 p.m., a family member indicated they had a difficult time gaining access to the resident. The staff failed to answer both the front doors when locked and also failed to answer the doorbell to the Memory Care Unit The closed clinical record for Resident B was reviewed on 2/14/22 at 1:23 p.m. Diagnoses included, but were not limited to, dementia and syncope. Resident B was admitted to the facility on 1/17/22 and discharged on 1/28/22. 2. During a interview on 2/15/22 at 10:45 a.m., a family member indicated they were already looking for another facility because the resident's needs were not being met. A family member recently waited 20 minutes to just be let into the unit for a visit. They have to wait a long time for someone to answer the doorbell into the locked unit and it was worse after hours. The facility promoted they could meet the needs of the residents, but they were not and several several families were unhappy with the care. The clinical record for Resident F was reviewed on 2/15/22 at 11:10 a.m. Diagnoses included,		to ensure that the alleged deficient practice does not recur; A) Visitation hours were posted at the front entrance, along with the number to call for after hours access; B) Two additional doorbell chimes were purchased for the MC unit (one kept as an emergency back-up/one immediately placed on the unit near the nursing office); and C) Prompts were added to the main lines phones with access to nursing office extensions. • The corrective action will be monitored to ensure the alleged deficient practice will not recur; A) ED or designee will test the nursing response to the doorbell on MC unit 5 x weekly x 3 weeks, then 2 x weekly x 2 weeks, then weekly on-going to ensure that nursing staff are responding promptly, B) ED or designee will test doorbell chimes weekly to ensure they are working appropriately; C) Any doorbell chimes found to be non-functional or missing will be replaced immediately. •	

	but were not limited to, dementia, hypertension and congestive heart disease. Review of a pre-admission assessment, dated 12/30/21, Resident F required stand-by assistance with showers, assistance with walking with a walker and meal preparation. An unsigned service plan, dated 1/15/22, indicated the resident was independent with bathing and supervision with walking. During an interview on 2/15/22 at 9:42 a.m., the Administrator indicated the families of the residents on the Memory Care Unit had recently formed their own committee to voice concerns. She recently attended their meeting at their request and felt some of the issues had been resolved. No additional information was provided. During an interview on 2/15/22 at 12:51 p.m., the Administrator indicated they had 2 bases for the doorbell into the locked unit and one seemed to be missing. The one that was missing was nearest to the nurses' station. She planed to replace as soon as possible.		The date the systemic changes will be completed; March 17th, 2022.	

During an interview on 2/15/22, Employee 3 indicated it has been an on-going issue that families had to wait long periods of time to be let in the facility or the locked unit.

Review of a current undated facility policy, titled "Resident's Personal Rights Policy and Procedure", provided by the Administrator on 2/15/22 at 12:44 p.m., indicated the following:

"PURPOSE:

The Statement of Resident's Personal Rights is included in the Resident's Admission Agreement....

...12. Have visitors of his or her choice to the extent of health, safety and well-being of others are not disturbed and the provisions of the resident contracts are upheld...."

This State tag relates to Complaint IN00372330 and IN00372386.

Based on interview and record review, the facility failed to provide reasonable visitation for 2 of 3 residents reviewed for rights. (Resident B and F).

Findings include:

During an observation on 2/14/22 at 2:48 p.m., after several minutes of ringing the

	doorbell to gain entry into the Memory Care Unit, CNA 1 and CNA 2 were observed in the work station on their personal phones. CNA 1 indicated she was about to leave so she was on her cell phone and did not hear the doorbell. 1. During a telephone interview on 2/14/22 at 12:55 p.m., a family member indicated they had a difficult time gaining access to the resident. The staff failed to answer both the front doors when locked and also failed to answer the doorbell to the Memory Care Unit The closed clinical record for Resident B was reviewed on 2/14/22 at 1:23 p.m. Diagnoses included, but were not limited to, dementia and syncope. Resident B was admitted to the facility on 1/17/22 and discharged on 1/28/22. 2. During a interview on 2/15/22 at 10:45 a.m., a family member indicated they were already looking for another facility because the resident's needs were not being met. A family member recently waited 20 minutes to just be let into the unit for a visit. They have to wait a long time for someone to answer the doorbell into the locked unit and it was worse after hours. The facility promoted they could meet the needs of the residents, but they			

	were not and several several families were unhappy with the care. The clinical record for Resident F was reviewed on 2/15/22 at 11:10 a.m. Diagnoses included, but were not limited to, dementia, hypertension and congestive heart disease. Review of a pre-admission assessment, dated 12/30/21, Resident F required stand-by assistance with showers, assistance with walking with a walker and meal preparation. An unsigned service plan, dated 1/15/22, indicated the resident was independent with bathing and supervision with walking. During an interview on 2/15/22 at 9:42 a.m., the Administrator indicated the families of the residents on the Memory Care Unit had recently formed their own committee to voice concerns. She recently attended their meeting at their request and felt some of the issues had been resolved. No additional information was provided.			

	During an interview on 2/15/22 at 12:51 p.m., the Administrator indicated they had 2 bases for the doorbell into the locked unit and one seemed to be missing. The one that was missing was nearest to the nurses' station. She planed to replace as soon as possible. During an interview on 2/15/22, Employee 3 indicated it has been an on-going issue that families had to wait long periods of time to be let in the facility or the locked unit. Review of a current undated facility policy, titled "Resident's Personal Rights Policy and Procedure", provided by the Administrator on 2/15/22 at 12:44 p.m., indicated the following: "PURPOSE: The Statement of Resident's Personal Rights is included in the Resident's Admission Agreement.... ...12. Have visitors of his or her choice to the extent of health, safety and well-being of others are not disturbed and the provisions of the resident contracts are upheld...." This State tag relates to Complaint IN00372330 and IN00372386.			

R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.	R 0090	**R 090** • The corrective action that will be accomplished for those residents found to have been affected by the alleged deficient practice; A reportable was filed on 2-15-2022 on the alleged possible medication error. • How the facility will identify other residents having the potential to be affected by the alleged deficient practice and the corrective action that will be taken; A) A review of all clinical notes was complete and no other possible reportable medication errors were found. • The measures put in place and systemic changes the facility will make to ensure that the alleged deficient practice does not recur; A) ED or designee will review the daily clinical record to ensure that all possible medication errors have been reported to the ISDH; B) All possible medication errors will	03/17/2022

	(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to report a possible medication error, which may have resulted in a fall with injury for 1 of 3 residents reviewed for accidents. (Resident C) The facility also failed to conduct a thorough investigation of a possible medication error. (Resident C)		be thoroughly investigation and reported within 24 hours; C) Licensed nursing staff will be re-educated to notify the DON or Administrator immediately for any possible medication errors; and D) All medication errors will be logged in the medication error binder. • The corrective action will be monitored to ensure the alleged deficient practice will not recur; A) ED or designee will audit the clinical record 5 x weekly x 3 weeks, then 2 x weekly x 2 weeks, then weekly on-going to ensure that all possible medication errors have been reported to the ISDH within 24 hours ; B) All possible medication errors will be thoroughly investigated and reported within 24 hours; C) Licensed nursing staff will be re-educated to report any possible medication errors immediately to the DON or ED ; and D) Audits of the medication error log will be reviewed at Quarterly QA committee and the QA committee will make further recommendations based off the audits.	

	Findings include: The clinical record for Resident C was reviewed on 2/14/22 at 1:39 p.m. Diagnoses included, but were not limited to, dementia, diabetes mellitus and hypertension. A progress note, dated 12/26/21 at 7:50 p.m., indicated Resident C had an observed fall. The resident was reaching for the medication room window and fell backwards. Resident C was noted to be bleeding and 911 was called to transport. A progress note, dated 12/26/21 at 8:05 p.m., indicated Emergency Medical Services (EMS) arrived and transported Resident C to the Emergency Room (ER). An ER report, dated 12/26/21, indicated the resident had a one inch round hematoma to the back of her head with minor swelling. She had a small laceration in the middle of the hematoma and slow bleeding. Her mental status was unchanged. Resident C returned to the facility on 12/26/21 at 11:00 p.m. with two staples to the upper left back of her head. A progress note, dated 12/27/21 at 6:07 p.m., indicated staff found Resident C on the floor near her bathroom with a large		• The date the systemic changes will be completed; March 17th, 2022.	

amount of blood at the back of her head. Pressure was applied to the wound and EMS was called and the resident was transported to the hospital.

A progress note, dated 12/27/21 at 11:00 p.m., indicated the ER physician called and informed staff the resident had benzodiazepines in her system from a drug screen.

Review of a patient summary report, dated 12/27/21, the physician indicated it was unclear how the resident had benzodiazepines in her urine. The EMS report showed no evidence of any being given. The resident was noted to have two lacerations at the back of her head, one with staples no longer intact. The two wounds measured two cm, both wear cleaned and stapled.

A late entry progress note for 12/28/21 at 10:00 a.m., dated 1/6/22 at 1:52 p.m., indicated the nurse for the primacy physician was informed per hospital discharge orders the resident had tested positive for benzodiazepine. The nurse indicated the physician was out for the remaining week and she would follow up with him on Monday.

A statement by the Memory Care Director (MCD) was provided on 2/15/22 at 9:21

	a.m. The statement, dated 1/6/22, indicated the resident had tested positive for benzodiazepines, but did not have an order for any benzodiazepines. The resident's apartment was searched and no medication was found. The Power of Attorney (POA) for Resident C was informed of the test results and questioned if the resident may have gotten another resident's medication. The POA was assured all narcotics were accounted for and there was no evidence a medication error occurred. During an interview on 2/15/22 at 9:07 a.m., the Administrator indicated the incident was not reported to the Indiana Department of Health (IDOH) but it was discussed with the corporate office. The Administrator did not obtain any written or verbal statements from staff working during the time of the possible medication error. During an interview on 2/15/22 at 9:21 a.m., the MCD indicated she was asked to write up a statement related to the benzodiazepines being found in Resident C's system and give to the Administrator. She indicated the resident was unable to self-medicate and staff administered all medications. Review of a current undated			

	facility policy, titled "Incident Report", provided by the Administrator on 2/15/22 at 12:44 p.m., indicated the following: "PURPOSE: To ensure timely, complete reporting and appropriate follow-up of any occurrence involving a resident, staff member, family member, and/or visitor. PROCEDURE: A. Document the following on the form: 1. Name of person involved. ...3. List individual's diagnosis that may have contributed to the incident.... ...12. Record the name(s) of witnesses and other comments. This State tag relates to Complaint IN00369959 and IN00372386.			

Based on interview and record review, the facility failed to report a possible medication error, which may have resulted in a fall with injury for 1 of 3 residents reviewed for accidents. (Resident C) The facility also failed to conduct a thorough investigation of a possible medication error. (Resident C)

Findings include:

The clinical record for Resident C was reviewed on 2/14/22 at 1:39 p.m. Diagnoses included, but were not limited to, dementia, diabetes mellitus and hypertension.

A progress note, dated 12/26/21 at 7:50 p.m., indicated Resident C had an observed fall. The resident was reaching for the medication room window and fell backwards. Resident C was noted to be bleeding and 911 was called to transport.

A progress note, dated 12/26/21 at 8:05 p.m., indicated Emergency Medical Services (EMS) arrived and transported Resident C to the Emergency Room (ER).

An ER report, dated 12/26/21, indicated the resident had a one inch round hematoma to the back of her head with minor swelling. She had a small laceration in the middle of the hematoma and slow bleeding.

Her mental status was unchanged.

Resident C returned to the facility on 12/26/21 at 11:00 p.m. with two staples to the upper left back of her head.

A progress note, dated 12/27/21 at 6:07 p.m., indicated staff found Resident C on the floor near her bathroom with a large amount of blood at the back of her head. Pressure was applied to the wound and EMS was called and the resident was transported to the hospital.

A progress note, dated 12/27/21 at 11:00 p.m., indicated the ER physician called and informed staff the resident had benzodiazepines in her system from a drug screen.

Review of a patient summary report, dated 12/27/21, the physician indicated it was unclear how the resident had benzodiazepines in her urine. The EMS report showed no evidence of any being given. The resident was noted to have two lacerations at the back of her head, one with staples no longer intact. The two wounds measured two cm, both wear cleaned and stapled.

A late entry progress note for 12/28/21 at 10:00 a.m., dated 1/6/22 at 1:52 p.m., indicated the nurse for the primacy physician was informed per

	hospital discharge orders the resident had tested positive for benzodiazepine. The nurse indicated the physician was out for the remaining week and she would follow up with him on Monday. A statement by the Memory Care Director (MCD) was provided on 2/15/22 at 9:21 a.m. The statement, dated 1/6/22, indicated the resident had tested positive for benzodiazepines, but did not have an order for any benzodiazepines. The resident's apartment was searched and no medication was found. The Power of Attorney (POA) for Resident C was informed of the test results and questioned if the resident may have gotten another resident's medication. The POA was assured all narcotics were accounted for and there was no evidence a medication error occurred. During an interview on 2/15/22 at 9:07 a.m., the Administrator indicated the incident was not reported to the Indiana Department of Health (IDOH) but it was discussed with the corporate office. The Administrator did not obtain any written or verbal statements from staff working during the time of the possible medication error. During an interview on 2/15/22			

	at 9:21 a.m., the MCD indicated she was asked to write up a statement related to the benzodiazepines being found in Resident C's system and give to the Administrator. She indicated the resident was unable to self-medicate and staff administered all medications. Review of a current undated facility policy, titled "Incident Report", provided by the Administrator on 2/15/22 at 12:44 p.m., indicated the following: "PURPOSE: To ensure timely, complete reporting and appropriate follow-up of any occurrence involving a resident, staff member, family member, and/or visitor. PROCEDURE: A. Document the following on the form: 1. Name of person involved. ...3. List individual's diagnosis that may have contributed to the incident.... ...12. Record the name(s) of witnesses and other comments. This State tag relates to Complaint IN00369959 and IN00372386.			

R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.	R 0217	**R 217** • The corrective action that will be accomplished for those residents found to have been affected by the alleged deficient practice; Resident B was discharged to home with family, Care plans were completed and signed for residents D, E and F. • How the facility will identify other residents having the potential to be affected by the alleged deficient practice and the corrective action that will be taken; A) All residents have the potential to be affected by alleged deficient practice. • 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 complete an audit for any care plans overdue or requiring signatures; B) DON or designee scheduled/hold care plan conferences to review updates	03/17/2022

	(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure resident service planes were updated and accurate for 4 of 5 residents reviewed for service plans. (Resident B, D, E and F) Findings include: 1. During a telephone interview on 2/14/22 at 12:55 p.m., a family member indicated they had a difficult time gaining access to the resident. The staff failed to answer both the front doors when locked and also failed to answer the doorbell to the Memory Care Unit. The closed clinical record for Resident B was reviewed on 2/14/22 at 1:23 p.m. Diagnoses included, but were not limited to, dementia and syncope. Resident B was admitted to the facility on 1/17/22 and discharged on 1/28/22. Review of a pre-admission assessment, dated 1/10/22, Resident B did not need assistance with dressing, walking, standing or transfers. An unsigned service plan, dated		with resident/family; and C) DON or designee will complete monthly audits of any care plans coming due to ensure care plans are reviewed and signed timely. • The corrective action will be monitored to ensure the alleged deficient practice will not recur; A) Director of Nursing or designee will audit care plan schedule to ensure all care plans will reviewed and signed by resident/family; and B) Audits will be reviewed at the Quarterly QA committee meeting and the QA committee will make further recommendations based off the audits. • The date the systemic changes will be completed; March 17th, 2022.	

1/17/22, indicated the resident required supervision with bathing and dressing.

2. During an interview on 2/14/22 at 10:46 a.m., Resident D indicated they do not do or update service plans. She could not remember the last time one was completed.

The clinical record for Resident D was reviewed on 2/14/22 at 1:05 p.m. Diagnoses included, but were not limited to, chronic kidney disease, hypertension chronic obstructive pulmonary disease and osteoarthritis.

A service plan was provided by the Director of Nursing (DON) on 2/15/22 at 10:55 a.m. The service plan was dated 8/26/19. The resident and/or family did not sign the service plan. The service plan indicated the resident was independent with bathing, dressing, walking, transfers and laundry.

On 2/15/22 at 10:55 a.m., the DON provided an updated service plan, dated 2/14/22. The updated service plan indicated the resident required set-up and oversight when bathing. The resident also required assistance with laundry. The service plan was signed by the resident on 2/14/22.

3. On 2/14/22 at 10:08 a.m., a family member for Resident E indicated they had never had a

care plan meeting or service plan with the facility. The resident was currently on hospice care and they visited almost daily.

A service plan was provided by the DON on 2/15/22 at 10:55 a.m. The service plan was dated 6/21/19. The resident and/or family did not sign the service plan. The service plan indicated the resident was hands on assist with bathing and dressing. She was independent with walking and transfers.

On 2/15/22 at 10:55 a.m., the DON provided an updated service plan, dated 2/14/22. The updated service plan indicated the resident required assistance with bathing and dressing. The resident also required the use of a walker to ambulate. The service plan was signed by the resident on 2/14/22.

4. During a family interview on 2/15/22 at 10:45 a.m., a family member indicated they were already looking for another facility because his needs were not being met. The facility promoted they could meet the needs of the residents, but they were not and several families were unhappy with the care.

The clinical record for Resident F was reviewed on 2/15/22 at 11:10 a.m. Diagnoses included, but were not limited to,

dementia, hypertension and congestive heart disease.

Review of a pre-admission assessment, dated 12/30/21, Resident F required stand-by assistance with showers, assistance with walking with a walker and meal preparation.

An unsigned service plan, dated 1/15/22, indicated the resident was independent with bathing and supervision with walking.

During an interview on 2/15/22 at 9:02 a.m., the DON indicated the service plans for Resident D and E were completed yesterday; 2/14/22. She had been the DON since July and was aware the service plans needed to be completed and signed.

Review of a current policy, last revised 2/12/21, titled "Residency Admission and Tenancy Requirement" was provided by the Administrator on 2/15/22 at 10:55 a.m. The policy indicated the following:

"The Community is licensed as a Residential Care Facility....The Community must satisfy all the following conditions for admission and residency:

...To ensure the welfare and safety of our potential residents/current residents, we must provide

services....Resident's services are in compliance with the Residential Regulations...."

This State residential finding relates to Complaint IN00369959, IN00372330 and IN00372386.

Based on record review and interview, the facility failed to ensure resident service planes were updated and accurate for 4 of 5 residents reviewed for service plans. (Resident B, D, E and F)

Findings include:

1. During a telephone interview on 2/14/22 at 12:55 p.m., a family member indicated they had a difficult time gaining access to the resident. The staff failed to answer both the front doors when locked and also failed to answer the doorbell to the Memory Care Unit.

The closed clinical record for Resident B was reviewed on 2/14/22 at 1:23 p.m. Diagnoses included, but were not limited to, dementia and syncope. Resident B was admitted to the facility on 1/17/22 and discharged on 1/28/22.

Review of a pre-admission assessment, dated 1/10/22, Resident B did not need assistance with dressing, walking, standing or transfers.

An unsigned service plan, dated 1/17/22, indicated the resident required supervision with bathing and dressing.

2. During an interview on 2/14/22 at 10:46 a.m., Resident D indicated they do not do or update service plans. She could not remember the last time one was completed.

The clinical record for Resident D was reviewed on 2/14/22 at 1:05 p.m. Diagnoses included, but were not limited to, chronic kidney disease, hypertension chronic obstructive pulmonary disease and osteoarthritis.

A service plan was provided by the Director of Nursing (DON) on 2/15/22 at 10:55 a.m. The service plan was dated 8/26/19. The resident and/or family did not sign the service plan. The service plan indicated the resident was independent with bathing, dressing, walking, transfers and laundry.

On 2/15/22 at 10:55 a.m., the DON provided an updated service plan, dated 2/14/22. The updated service plan indicated the resident required set-up and oversight when bathing. The resident also required assistance with laundry. The service plan was signed by the resident on 2/14/22.

3. On 2/14/22 at 10:08 a.m., a family member for Resident E

indicated they had never had a care plan meeting or service plan with the facility. The resident was currently on hospice care and they visited almost daily.

A service plan was provided by the DON on 2/15/22 at 10:55 a.m. The service plan was dated 6/21/19. The resident and/or family did not sign the service plan. The service plan indicated the resident was hands on assist with bathing and dressing. She was independent with walking and transfers.

On 2/15/22 at 10:55 a.m., the DON provided an updated service plan, dated 2/14/22. The updated service plan indicated the resident required assistance with bathing and dressing. The resident also required the use of a walker to ambulate. The service plan was signed by the resident on 2/14/22.

4. During a family interview on 2/15/22 at 10:45 a.m., a family member indicated they were already looking for another facility because his needs were not being met. The facility promoted they could meet the needs of the residents, but they were not and several families were unhappy with the care.

The clinical record for Resident F was reviewed on 2/15/22 at 11:10 a.m. Diagnoses included,

but were not limited to, dementia, hypertension and congestive heart disease.

Review of a pre-admission assessment, dated 12/30/21, Resident F required stand-by assistance with showers, assistance with walking with a walker and meal preparation.

An unsigned service plan, dated 1/15/22, indicated the resident was independent with bathing and supervision with walking.

During an interview on 2/15/22 at 9:02 a.m., the DON indicated the service plans for Resident D and E were completed yesterday; 2/14/22. She had been the DON since July and was aware the service plans needed to be completed and signed.

Review of a current policy, last revised 2/12/21, titled "Residency Admission and Tenancy Requirement" was provided by the Administrator on 2/15/22 at 10:55 a.m. The policy indicated the following:

"The Community is licensed as a Residential Care Facility....The Community must satisfy all the following conditions for admission and residency:

...To ensure the welfare and safety of our potential residents/current residents, we

	must provide services....Resident's services are in compliance with the Residential Regulations...." This State residential finding relates to Complaint IN00369959, IN00372330 and IN00372386.			

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