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 the Investigation of Complaint IN00361476. This visit included a COVID-19 Quality Assurance Walk-through. 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 a 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 IN00351557 completed on 4/20/21.	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 a PSR to the Investigation of Complaint IN00360659 completed on 8/24/21 Complaint IN00361476.- Substantiated. State Residential Findings related to the allegations are cited at R0041. 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; (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,	R 0041	**R 041** •The corrective action that will be accomplished for those residents found to have been affected by the alleged deficient practice; Resident B, C, D, E and M had no negative affects related to alleged deficient practice. •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 AL 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) Additional staff members have been hired for nursing, and dietary departments; B) Meal service has been broken into two seating times - A & B, to address the practice of all AL residents eating in the dining room at the same time; C) Dining staff will take sections and serve on a first come/first serve basis; D) DON or designee will in-service nursing staff on appropriate call light times; E) DON or designee will review daily call logs for response times over 10 minutes; F) Nursing supervisor will carry pendant phone while	11/12/2021

	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		in community to assist with responding to call lights; G) All new dietary staff will be trained on dining room service during job specific orientation and all new nursing staff will be trained on appropriate response to call lights during orientation; and H) New staff members were added to the schedule upon completion of orientation. •The corrective action will be monitored to ensure the alleged deficient practice will not recur; A) Administrator or designee will monitor the dining room service 5 x weekly x 3 weeks, then 2 x weekly x 2 weeks, then weekly on-going to ensure that meal service is timely; B) DON and/or designee will review the call light report 5 days week x 2 weeks, weekly x 2 months then monthly x 6 months; C) Audits will be reviewed at Quarterly QA committee and the QA committee will make further recommendations based off the audits. •The date the systemic changes will be completed; November 12th, 2021.	

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.

This residential tag relates to complaint number IN00361476.

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. This residential tag relates to complaint number IN00361476.			

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