STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/24/2021

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 IN00361476. This visit included a COVID 19 Quality Assurance Walk-through completed on 10/06/21 This visit was in conjunction with a PSR to Investigation of Complaints IN00353102 and IN00354013 completed on 6/1/21. This visit was in conjunction with a PSR to Investigation of Complaint IN00360659 completed on 8/24/21. This visit was in conjunction with a PSR to Investigation of Complaint IN00351557 completed on 4/20/21. Complaint IN00361476 - Not corrected. Survey dates: November 23 & 24, 2021	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 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 stated 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.	

	Facility number: 014213 Residential Census: 119 This State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 2, 2021. This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00361476. This visit included a COVID 19 Quality Assurance Walk-through completed on 10/06/21 This visit was in conjunction with a PSR to Investigation of Complaints IN00353102 and IN00354013 completed on 6/1/21. This visit was in conjunction with a PSR to Investigation of Complaint IN00360659 completed on 8/24/21. This visit was in conjunction with a PSR to Investigation of Complaint IN00351557 completed on 4/20/21. Complaint IN00361476 - Not corrected. Survey dates: November 23 & 24, 2021 Facility number: 014213			

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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 on record review and interview, the facility failed to audit call light wait times per facility plan of correction for resolution of resident grievances regarding long call light waits, resulting in a resident waiting 51 minutes for assistance following a fall with major injury for 1 of 3 residents reviewed for long call light wait. (Resident P) Findings include:	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 P was transported to the hospital for treatment, followed by extensive rehab and return to the community is pending. • 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	12/20/2021

During a review of the facility call light logs, provided by the Corporate Operations Manager Consultant on 11/24/21 at 12:03 p.m., there were 166 entries of call lights over 15 minutes from 11/12/21 to 11/22/21, which included 84 alerts over 30 minutes, and 38 alerts over 60 minutes.

A clinical record review for Resident P was completed on 11/24/21 at 10:57 a.m. Diagnoses included, but were not limited to, dementia and diabetes mellitus. The resident resided on the memory care unit.

A nursing progress note, dated 11/13/21, indicated the resident was found on her bathroom floor on her right side. The resident indicated she had pain to her right hip and was sent to the emergency room and admitted with a right hip fracture.

A review of the facility's call light log, indicated the resident had initiated her bathroom call light at 10:40 p.m. The staff was alerted 17 times. The call light was turned off at 11:31 p.m., 51 minutes after the initial alert.

During a telephone interview on 11/24/21 at 12:57 p.m., LPN 3 indicated the QMA who found the resident in her bathroom was answering a call light. LPN 3 was unable to provide an

to ensure that the alleged deficient practice does not recur; A) Administrator or designee will review the call light log daily Monday-Friday; B) Administrator or designee will follow up on all call lights over 15 minutes to assure that all resident needs were met and determine the cause of the extended response time. This may include employee follow up and education; C) Follow up on call lights longer than 15 minutes will be documented accordingly and will be reviewed by the community's regional team weekly; and D) Direct care staff shall be re-educated regarding the importance of call light response.

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The corrective action will be monitored to ensure the alleged deficient practice will not recur; A) Administrator or designee will review the call light log 5 x weekly and Administrator or designee will follow up on call lights over 15 minutes 5 x weekly on-going to ensure that all resident needs were met and determine the cause of the extended response time; C) Follow up on call lights longer than 15 minutes will be documented

	explanation for the lengthy response time in answering the resident's call light. During an interview on 11/24/21 at 9:55 a.m., the Administrator indicated she had completed an inservice with staff on 10/7/21, regarding call light response times. She provided documentation of what had been included regarding this topic during her inservicing, as follows: A document, titled, "PENDANT PHONES/CALL LIGHT RESPONSE, " included, but was not limited to, "Call light response should be 10 to 15 minutes." A document, titled, "Call Lights Are the Residents' Connection to Urgent & Needed Care," included, but was not limited to, "Assume each call light is an emergency We must assure the safety and well-being of our residents Call lights must be answered as quickly as possible Call light reports are being reviewed by leadership daily" During an interview on 11/24/21 at 9:55 a.m., the Director of Nursing (DON) indicated she reviewed the call light logs and		accordingly and will be reviewed by the community's regional team weekly; D) Direct care staff shall be re-educated regarding the importance of call light response; and E) 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; December 20th, 2021.	

interviewed residents and staff regarding any wait over 10 minutes. She did not document her audit information or her investigation information or occurrences.

This deficiency was cited on 10/6/21. The facility failed to implement a systemic plan of correction to prevent recurrence.

Based on record review and interview, the facility failed to audit call light wait times per facility plan of correction for resolution of resident grievances regarding long call light waits, resulting in a resident waiting 51 minutes for assistance following a fall with major injury for 1 of 3 residents reviewed for long call light wait. (Resident P)

Findings include:

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resided on the memory care unit.

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A document, titled, "PENDANT PHONES/CALL LIGHT RESPONSE, " included, but

was not limited to,

"Call light response should be 10 to 15 minutes."

A document, titled, "Call Lights Are the Residents' Connection to Urgent & Needed Care," included, but was not limited to,

"Assume each call light is an emergency

We must assure the safety and well-being of our residents

Call lights must be answered as quickly as possible

Call light reports are being reviewed by leadership daily"

During an interview on 11/24/21 at 9:55 a.m., the Director of Nursing (DON) indicated she reviewed the call light logs and interviewed residents and staff regarding any wait over 10 minutes. She did not document her audit information or her investigation information or occurrences.

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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