

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 04/24/2023
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 IN00406722. Complaint IN00406722 - State deficiencies related to the allegations are cited at R0090 and R0144. Survey dates: April 21 and 24, 2023 Facility number: 014213 Residential Census: 124 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 1, 2023.	R 0000			
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	R 0090	R 090 What corrective action(s) will be accomplished for those	06/01/2023	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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.

(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:

residents found to have been affected by the deficient practice;

- No negative outcomes identified for the resident found to have been affected.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

- All memory care residents had the potential to be affected. No residents were adversely affected.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;

- Lori Davenport IHCA/NCAL to review and provide, to the Executive Director, education of the current Indiana Department of Health policy, dated 12/08/2022 titled

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	(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 to the appropriate agencies the elopement of a cognitively impaired resident from the secured memory care unit. (Resident B) Findings include: The clinical record for Resident B was reviewed on 4/21/2023 at 10:30 a.m. Diagnoses included, dementia, hyperlipidemia, hypothyroid, tachycardia, and pre-diabetes. The resident was living on the secured memory care unit. A progress note, dated 4/3/2023 at 1:30 a.m., indicated on		"Long -Term Care Abuse and Incident Reporting Policy" defining elopement and reporting. Executive Director educated that elopement definition includes: "... Elopement: Elopement occurs when a resident without decision making capacity leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so OR a resident with decision making capacity leaves the premises or a safe area, without facility knowledge, and does not return as per the resident plan of care or service plan, related to leaving the facility...." Training occurred on 5/11/23 (attached) • Facility staff educated on definition of elopement and proper reporting policy • Education added to new hire employment to include elopement and reporting	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	4/2/2023 at 7:26 p.m., the resident had left the secured memory care unit unsupervised and was found on the assisted living unit on the second floor. The resident was returned to the memory care unit by assisted living staff. The progress note lacked documentation of the last time the resident was seen on the secured memory care unit prior to being discovered on the assisted living unit. During an interview on 4/21/2023 at 12:00 p.m., the Administrator indicated on or about 3/27/2023 the zero key on the laundry room door key pad had come off. The door could not be opened without the missing zero number pad. On the other side of the keypad was a dead bolt lock. Someone had unlocked the door to allow entrance into the laundry room. The Administrator had been unaware the lock was broken. On 4/2/2023, Resident B had been making laps around the unit and was able to leave the secured unit unsupervised, through the laundry room door. Staff on the assisted living unit saw the resident on the second floor and escorted the resident back to the memory care unit. A time line provided by the Administrator on 4/21/2023 at 12:41 p.m., indicated at 7:15 p.m. the resident took an unsupervised walk and was		How the corrective actions will be monitored to ensure the deficient practice will not recur? • Executive Director or designee will audit all incidents weekly x 4 weeks, then monthly x 4 months and then randomly to ensure IDOH reporting policy is followed. • QA Committee will review audits and make recommendations By what date the systemic changes will be complete • 6/1/23	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

seen on the second floor of the assisted living at 7:24 p.m. The Administrator indicated the facility did not feel the event was reportable to the state agency because the resident had not left the building.

Review of a current Indiana Department of Health policy, dated 12/8/2022, titled "Long-Term Care Abuse and Incident Reporting Policy" defined elopement as the following:

".... Elopement: Elopement occurs when a resident without decision making capacity leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so OR a resident with decision making capacity leaves the premises or a safe area, without facility knowledge, and does not return as per the resident plan of care or service plan, related to leaving the facility...."

No further information was provided prior to exit from the facility.

This state residential finding is related to Complaint IN00406722.

Based on interview and record review, the facility failed to report to the appropriate agencies the elopement of a

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

cognitively impaired resident from the secured memory care unit. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 4/21/2023 at 10:30 a.m. Diagnoses included, dementia, hyperlipidemia, hypothyroid, tachycardia, and pre-diabetes. The resident was living on the secured memory care unit.

A progress note, dated 4/3/2023 at 1:30 a.m., indicated on 4/2/2023 at 7:26 p.m., the resident had left the secured memory care unit unsupervised and was found on the assisted living unit on the second floor. The resident was returned to the memory care unit by assisted living staff. The progress note lacked documentation of the last time the resident was seen on the secured memory care unit prior to being discovered on the assisted living unit.

During an interview on 4/21/2023 at 12:00 p.m., the Administrator indicated on or about 3/27/2023 the zero key on the laundry room door key pad had come off. The door could not be opened without the missing zero number pad. On the other side of the keypad was a dead bolt lock. Someone had unlocked the door to allow entrance into the laundry room.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

The Administrator had been unaware the lock was broken. On 4/2/2023, Resident B had been making laps around the unit and was able to leave the secured unit unsupervised, through the laundry room door. Staff on the assisted living unit saw the resident on the second floor and escorted the resident back to the memory care unit.

A time line provided by the Administrator on 4/21/2023 at 12:41 p.m., indicated at 7:15 p.m. the resident took an unsupervised walk and was seen on the second floor of the assisted living at 7:24 p.m. The Administrator indicated the facility did not feel the event was reportable to the state agency because the resident had not left the building.

Review of a current Indiana Department of Health policy, dated 12/8/2022, titled "Long-Term Care Abuse and Incident Reporting Policy" defined elopement as the following:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	a safe area, without facility knowledge, and does not return as per the resident plan of care or service plan, related to leaving the facility...." No further information was provided prior to exit from the facility. This state residential finding is related to Complaint IN00406722.			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure hazardous materials were secured out of reach of cognitively impaired residents. The facility also failed to ensure secured doors were operational to prevent resident elopement. These deficient practices had the potential to effect 30 ambulatory residents of 31 residents who lived on the secured memory care unit and resulted in 1 resident leaving the secured unit unsupervised. (Resident B)	R 0144	R 144 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • No negative outcomes identified for the resident found to have been affected. How the facility will identify other residents have the potential to be affected by the same deficient practice; • All memory care residents had the potential to be affected. No residents were adversely affected. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient	06/01/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Findings include:

1. During a facility tour, on 4/21/2023 between 10:00 a.m. and 10:27 a.m., the secured unit was observed as having floor renovations. Work areas were designated by yellow caution tape. The following hazardous materials/items were observed in the area, unattended:

- a. One gallon bottle of Primer L
- b. One gallon of acetone
- c. One gallon of odorless mineral spirits
- d. One gallon of denatured alcohol
- e. One hook knife
- f. One blow torch

At 10:18 a.m. a construction worker arrived in the area, and indicated he had been taking out the trash.

During an interview on 4/21/2023 at 10:18 a.m., the Administrator indicated the hazardous items should not have been left unattended.

2. The clinical record for Resident B was reviewed on 4/21/2023 at 10:30 a.m. Diagnoses included, dementia, hyperlipidemia, hypothyroid, tachycardia, and pre-diabetes. The resident was living on the

practice does not recur

- Jack Laurie Floor technicians educated by memory care director on proper storage of chemicals in licensed care setting (4/25/23)

- All floor care chemicals were removed from common area and placed in safe storage area (4/21/23)

- Floor replacement work by Jack Laurie was completed on or before 4/28/23

- Door lock repaired (4/3/23)

- Heavy duty, tamper resistant lock utilized to replace original door lock (installed 4/10/23)

- Maintenance Director will provide Maintenance Work Order Request forms and will be located at each nurses station and outside the Maintenance Office for concerns communication

- Maintenance Director to in-service employees on General Safety, Hazard Communication and

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

secured memory care unit.

A progress note, dated 4/3/2023 at 1:30 a.m., indicated on 4/2/2023 at 7:26 p.m., the resident had left the secured memory care unit unsupervised and as found on the assisted living unit on the second floor. The resident was returned to the memory care unit by assisted living staff.

A time line provided, by the Administrator on 4/21/2023 at 12:41 p.m., indicated the at 7:15 p.m. the resident took an unsupervised walk and was seen on the second floor of the assisted living at 7:24 p.m. The Administrator indicated the facility did not feel the event was reportable to the state agency because the resident had not left the building.

During an interview on 4/21/2023 at 12:00 p.m., the Administrator indicated on or about 3/27/2023 the zero on the laundry room door key pad had come off. The door could not be opened with the missing zero number pad. On the other side of the keypad was a dead bolt lock. Someone had unlocked the door to allow entrance into the laundry room. The Administrator had been unaware the lock was broken. On 4/2/2023, Resident B had been making laps around the unit and was able to leave the

emergency notification for malfunctioning emergency equipment/locks

o Staff educated on necessity to immediately report to supervisor/Executive Director equipment failures that can result in resident safety concerns, such as elopement

• Maintenance
Director will instruct contractors performing work in the community to keep dangerous tools and chemicals secured even when they are gone only for several minutes

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

secured unit unsupervised through the laundry room door. Staff on the assisted living unit saw the resident on the second floor and escorted the resident back to the memory care unit.

During an interview on 4/24/2023 at 10:29 a.m., CNA 3 indicated the laundry room door had not been working properly for approximately a couple of months. CNA 3 indicated the numbers on the key pad would come off and the door had to be unlocked from the other side. The CNA indicated Resident B was known for exit seeking behaviors.

During an interview on 4/24/2023 at 12:39 p.m., CNA 1 indicated on 4/2/2023 at 7:24 p.m., the aide on the second floor of the assisted living unit indicated Resident B had been found on the second floor. CNA 1 called the memory care unit and told them the resident was on the assisted living unit. The resident was escorted back to the secured memory care unit. CNA 1 did not know how the resident had gotten off the unit, nor how long he had been off the secured memory care unit.

During an interview on 4/24/2023 at 1:16 p.m., the Maintenance Supervisor indicated they had not been aware the lock on the laundry room door had been broken

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

until he was told by the
Administrator on 4/23/2023.

No further information was
provided.

This state residential finding is
related to Complaint
IN00406722.

Based on observation and
interview, the facility failed to
ensure hazardous materials
were secured out of reach of
cognitively impaired residents.
The facility also failed to ensure
secured doors were operational
to prevent resident elopement.
These deficient practices had
the potential to effect 30
ambulatory residents of 31
residents who lived on the
secured memory care unit and
resulted in 1 resident leaving the
secured unit unsupervised.
(Resident B)

Findings include:

1. During a facility tour, on
4/21/2023 between 10:00 a.m.
and 10:27 a.m., the secured unit
was observed as having floor
renovations. Work areas were
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

mineral spirits

d. One gallon of denatured alcohol

e. One hook knife

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At 10:18 a.m. a construction worker arrived in the area, and indicated he had been taking out the trash.

During an interview on 4/21/2023 at 10:18 a.m., the Administrator indicated the hazardous items should not have been left unattended.

2. The clinical record for Resident B was reviewed on 4/21/2023 at 10:30 a.m. Diagnoses included, dementia, hyperlipidemia, hypothyroid, tachycardia, and pre-diabetes. The resident was living on the secured memory care unit.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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During an interview on 4/24/2023 at 10:29 a.m., CNA 3 indicated the laundry room door had not been working properly for approximately a couple of months. CNA 3 indicated the numbers on the key pad would come off and the door had to be unlocked from the other side. The CNA indicated Resident B

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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During an interview on 4//24/2023 at 1:16 p.m., the Maintenance Supervisor indicated they had not been aware the lock on the laundry room door had been broken until he was told by the Administrator on 4/23/2023.

No further information was provided.

This state residential finding is related to Complaint IN00406722.

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