STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/22/2022

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 Complaints IN00385380 and IN00385203. Complaint IN00385380 - Unsubstantiated due to lack of evidence. Complaint IN00385203 - Substantiated. State Residential Findings related to the allegations are cited at R0052. Unrelated deficiencies are cited. Survey date: July 21 an 22, 2022 Facility number: 014213 Residential Census: 105 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 28, 2022.	R 0000		

R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review the facility failed to ensure cognitively impaired residents were free from neglect and mistreatment for 3 of 6 residents reviewed for neglect (Resident B, Resident F and Resident G). This deficient practice resulted in Resident B being left on the floor in their room, unclothed and soiled for approximately 3 hours. Findings include: 1. The clinical record for Resident B was reviewed on 7/21/2022 at 1:15 p.m. Diagnoses included, but were not limited to, hypothyroidism, dementia without behavioral disturbance, arthritis, sciatica, metatarsalgia of the right and left foot. Review of a facility	R 0052	Noblesville POC Complaint survey 7/22/22 R0S2 Resident Rights- Offense 1. Resident B displayed no long term affect from deficient practice. Resident B is currently at Assurance Psychiatric hospital related to aggression towards others. CNA 4 was terminated from employment. Resident F and G remain in Memory Care and display no long term affects from deficient practice. CNA 1 was terminated from employment. 2. Residents living on memory care have potential to be affected from alleged deficient practice. No other residents identified during interviews with staff. 3. Resident Rights and Abuse/Neglect in-services were held either by Director of Nurse or Administrator through July 23, 2022-August 1, 2022 on all shifts. Regional Director of Health Services reviewed and consulted on material presented at in-service. Additional Abuse and Neglect information has been added to General Orientation. Director of Memory Care educated by	08/26/2022

	self-reportable, dated July 12, 2022, indicated CNA (Certified Nursing Aide)1 was accused of neglectful behaviors towards Resident B as evidenced by allowing the resident to sleep on the floor, naked for approximately 3 hours. Review of a facility self-reportable, dated July 13, 2922, indicated Resident B was found asleep on the floor and wet. Review of a written statement, dated 7/11/2022, by CNA 3 indicated CNA 4 had given report that Resident B was on the floor asleep. CNA 4 had checked on the resident at 3:00 a.m. the resident layed (SIC) down on the floor. When the day shift CNA checked, the resident was found "soaking wet and naked". During an interview on 7/21/2022 at 11:31 a.m., CNA 3 confirmed the information in the written statement. Review of a written interview, dated 7/11/2022, the Memory Care Director indicated CNA 4 stated she had left the resident on the floor because the resident "wanted to sleep on the floor". CNA 4 indicated the resident was naked but refused to get dressed. CNA 4 indicated she had not informed anyone nor requested help with the		Administrator on August 3, 2022 to monitor for caregiver stress. Employees identified will be re-assignment to Assisted Living for mental health break. Dementia care training with Director team scheduled for August 22, 2022 by the Regional Director of Health Services. Sensitivity training added to quarterly in-services. Addendum: Directors will immediately remove employee from care area if any sign of mistreatment of residents. The Administrator will make rotating schedule and will oversee monitoring observations, identifying any allegations of abuse, threating behavior, or vulgar language for minimum of 6 month 4. Administrator and/or designee will interview 5 staff members from all shifts/departments weekly to ensure no observations of abuse and neglect have been witnessed and not reported. Interview statements will be reviewed in Quality Assurance meetings monthly ongoing and make recommendations for need to in-service. 5. August 26, 2022	

	resident's behavior. 2. The clinical record for Resident F was reviewed on 7/22/2022 at 10:22 a.m. Diagnoses included, but were not limited to, anxiety disorder, chronic kidney disease stage 3 and dementia with behavioral disturbance. Review of the facility investigation indicated Resident F and Resident G were mistreated by CNA 1. A statement written, dated 7/5/2022, by CNA 2 indicated during the shift, CNA 1 refused to toilet residents. CNA 2 indicated they witnessed CNA 1 threatening Resident F every time the resident called for assistance. CNA 2 indicated CNA 1 would cuss, yell and scream at the residents when the residents refused to go to bed. CNA 2 indicated CNA 1 would call the residents inappropriate names. CNA 2 indicated residents were afraid of CNA 1 and would not come out of their rooms if CNA 1 was working. During the survey CNA 2 was unable to be reached for interview. 3. The clinical record for Resident G was reviewed on 7/22/2022 at 10:37 a.m. Diagnoses included, but were not limited to, hypothyroidism,			

depressive disorder, cognitive impairment and osteoporosis.

Review of a statement, dated 7/11/2022, written by a family member of Resident G , indicated CNA 1 verbally abused Resident G. The resident was walking between 8:00 p.m. and 9:00 p.m. during the week of July 2, 2022. CNA 1 saw the resident and told her to get back to her room now. The CNA did not use appropriate language and called the resident an inappropriate name. The family member indicated the resident likes to walk for exercise and does not bother anyone.

During an interview on 7/21/2022 at 10:20 a.m., the Administrator indicated CNA 1 had been terminate after the facility completed an investigation into the allegations.

This residential tag relates to complaint IN00385203.

Based on interview and record review the facility failed to ensure cognitively impaired residents were free from neglect and mistreatment for 3 of 6 residents reviewed for neglect (Resident B, Resident F and Resident G). This deficient practice resulted in Resident B being left on the floor in their room, unclothed and soiled for

approximately 3 hours.

Findings include:

1. The clinical record for Resident B was reviewed on 7/21/2022 at 1:15 p.m. Diagnoses included, but were not limited to, hypothyroidism, dementia without behavioral disturbance, arthritis, sciatica, metatarsalgia of the right and left foot.

Review of a facility self-reportable, dated July 12, 2022, indicated CNA (Certified Nursing Aide)1 was accused of neglectful behaviors towards Resident B as evidenced by allowing the resident to sleep on the floor, naked for approximately 3 hours.

Review of a facility self-reportable, dated July 13, 2922, indicated Resident B was found asleep on the floor and wet.

Review of a written statement, dated 7/11/2022, by CNA 3 indicated CNA 4 had given report that Resident B was on the floor asleep. CNA 4 had checked on the resident at 3:00 a.m. the resident layed (SIC) down on the floor. When the day shift CNA checked, the resident was found "soaking wet and naked".

During an interview on 7/21/2022 at 11:31 a.m., CNA 3

	confirmed the information in the written statement. Review of a written interview, dated 7/11/2022, the Memory Care Director indicated CNA 4 stated she had left the resident on the floor because the resident "wanted to sleep on the floor". CNA 4 indicated the resident was naked but refused to get dressed. CNA 4 indicated she had not informed anyone nor requested help with the resident's behavior. 2. The clinical record for Resident F was reviewed on 7/22/2022 at 10:22 a.m. Diagnoses included, but were not limited to, anxiety disorder, chronic kidney disease stage 3 and dementia with behavioral disturbance. Review of the facility investigation indicated Resident F and Resident G were mistreated by CNA 1. A statement written, dated 7/5/2022, by CNA 2 indicated during the shift, CNA 1 refused to toilet residents. CNA 2 indicated they witnessed CNA 1 threatening Resident F every time the resident called for assistance. CNA 2 indicated CNA 1 would cuss, yell and scream at the residents when the residents refused to go to bed. CNA 2 indicated CNA 1 would call the residents inappropriate names. CNA 2			

indicated residents were afraid of CNA 1 and would not come out of their rooms if CNA 1 was working.

During the survey CNA 2 was unable to be reached for interview.

3. The clinical record for Resident G was reviewed on 7/22/2022 at 10:37 a.m. Diagnoses included, but were not limited to, hypothyroidism, depressive disorder, cognitive impairment and osteoporosis.

Review of a statement, dated 7/11/2022, written by a family member of Resident G , indicated CNA 1 verbally abused Resident G. The resident was walking between 8:00 p.m. and 9:00 p.m. during the week of July 2, 2022. CNA 1 saw the resident and told her to get back to her room now. The CNA did not use appropriate language and called the resident an inappropriate name. The family member indicated the resident likes to walk for exercise and does not bother anyone.

During an interview on 7/21/2022 at 10:20 a.m., the Administrator indicated CNA 1 had been terminate after the facility completed an investigation into the allegations.

This residential tag relates to

	complaint IN00385203.			
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	R 0090	R090 Administration and Management - Deficiency 1. Resident B displayed no long term affect from deficient practice. Resident Bis currently at Assurance Psychiatric hospital related to aggression towards others. CNA 4 was terminated from employment. Resident F and G remain in Memory Care and display no long term affects from deficient practice. CNA 1 was terminated from employment. 2. Residents living on memory care have potential to be affected from alleged deficient practice. No other residents identified during interviews with staff. 3. Resident Rights and Abuse/Neglect inservices were held either by Director of Nurse or Administrator through July 23, 2022-August 1, 2022 on all shifts. Regional Director of Health Services reviewed and consulted on material presented at inservice. Additional Abuse and Neglect information has been added to General Orientation. Director of Memory Care educated by Administrator on August 3, 2022 to monitor for caregiver stress. Employees identified will be re-assignment to Assisted Living for mental health break. Dementia care training with Director team scheduled for August 22, 2022 by	08/12/2022

	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: (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 ensure staff reported an allegations of verbal abuse and mistreatment of residents immediately to the Department Manager or the Administrator per policy for 3 of 6 residents reviewed for neglect (Residents B, F, and G)		the Regional Director of Health Services. Sensitivity training added to quarterly inservices. 4. Administrator and/or designee will interview 5 staff members from all shifts/departments weekly to ensure no observations of abuse and neglect have been witnessed and not reported. Interview statements will be reviewed in Quality Assurance meetings monthly ongoing and make recommendations for need to inservice. 5. August 12, 2022	

Findings include:

Review of a facility self reportable, dated July 12, 2 022, indicated CNA (Certified Nursing Aide)1 was accused of neglectful behaviors towards Resident B, Resident F and Resident G. A statement written, dated 7/5/2022, by CNA 2 indicated during the night shift, CNA 1 refused to toilet residents. CNA 2 indicated they witnessed CNA 1 threatening Resident F every time the resident called for assistance. CNA 2 indicated CNA 1 would cuss, yell and scream at the residents when the residents refused to go to bed. CNA 2 indicated CNA 1 would call the residents inappropriate names. CNA 2 indicated residents were afraid of CNA 1 and would not come out of their rooms if CNA 1 was working. During the survey CNA 2 was unable to be reached for interview.

During an interview on 7/21/2022 at 1:45 p.m., the Administrator and the Memory Care Director indicated they had no prior knowledge to any mistreatment of residents on the memory care unit. They indicated until they received the written statement from CNA 1, they had not been notified of mistreatment of residents.

During an interview on 7/21/2022 at 11:31 a.m., CNA 3

indicated Resident B had been seen hitting other residents on top of the head with a fist. CNA 3 indicated they did not report the incident and thought others who had seen it had reported the incident.

During an interview on 7/21/2022 at 2:23 p.m., QMA (Qualified Medication Aide) 5 indicated she had seen Resident B hit another resident on top of the head with a fist. QMA 5 indicated she did not report the incident because she thought someone else had reported the incident to the Memory Care Director.

Review of a current policy, dated 1/2022, titled "Abuse, Neglect, and Financial Exploitation Prevention" indicted the following:

"...Reporting

It is mandatory for staff members to report suspected incidents of abuse, neglect, and financial exploitation. Staff members are required to immediately report suspected behaviors to their Department manager. Documentation will be initiated by the Department Manager at the time of the initial report. The Department Manager will immediately inform the Administrator. ..."

Based on interview and record review, the facility failed to

ensure staff reported an allegations of verbal abuse and mistreatment of residents immediately to the Department Manager or the Administrator per policy for 3 of 6 residents reviewed for neglect (Residents B, F, and G)

Findings include:

Review of a facility self reportable, dated July 12, 2 022, indicated CNA (Certified Nursing Aide)1 was accused of neglectful behaviors towards Resident B, Resident F and Resident G. A statement written, dated 7/5/2022, by CNA 2 indicated during the night shift, CNA 1 refused to toilet residents. CNA 2 indicated they witnessed CNA 1 threatening Resident F every time the resident called for assistance. CNA 2 indicated CNA 1 would cuss, yell and scream at the residents when the residents refused to go to bed. CNA 2 indicated CNA 1 would call the residents inappropriate names. CNA 2 indicated residents were afraid of CNA 1 and would not come out of their rooms if CNA 1 was working. During the survey CNA 2 was unable to be reached for interview.

During an interview on 7/21/2022 at 1:45 p.m., the Administrator and the Memory Care Director indicated they had no prior knowledge to any

mistreatment of residents on the memory care unit. They indicated until they received the written statement from CNA 1, they had not been notified of mistreatment of residents.

During an interview on 7/21/2022 at 11:31 a.m., CNA 3 indicated Resident B had been seen hitting other residents on top of the head with a fist. CNA 3 indicated they did not report the incident and thought others who had seen it had reported the incident.

During an interview on 7/21/2022 at 2:23 p.m., QMA (Qualified Medication Aide) 5 indicated she had seen Resident B hit another resident on top of the head with a fist. QMA 5 indicated she did not report the incident because she thought someone else had reported the incident to the Memory Care Director.

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	manager. Documentation will be initiated by the Department Manager at the time of the initial report. The Department Manager will immediately inform the Administrator. ..."			

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