STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NOBLESVILLE	9600 E 146TH STREET NOBLESVILLE, IN 46060

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00389303, IN00389404, IN00389652, IN00389658, IN00389939, and IN00389947. Complaint IN00389303 - Substantiated. State deficiencies related to the allegations are cited at R0052 and R0240. Complaint IN00389404 - Substantiated. State deficiency related to the allegations is cited at R0052. Complaint IN00389652 - Substantiated. State deficiencies related to the allegations are cited at R0027 and R0042. Complaint IN00389658 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00389939 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00389947 - Substantiated. State deficiencies related to the allegations are cited at R0027, R0144 and R0240. Unrelated deficiency is cited. Survey dates: September 13, 14, 15, and 16, 2022 Facility number: 014213 Residential Census: 117 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	Please see the plan of correction submitted for completion date 10 14 2022	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on 9/19/22.			
R 0027 Bldg. 00	410 IAC 16.2-5-1.2(b) Residents' Rights - Deficiency (b) Residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Based on observation, interview, and record review, the facility failed to ensure call lights were responded to in an adequate amount of time for residents reviewed for call light response times (Resident D and Memory Care Unit). This had the potential to affect all 30 residents on the Memory Care Unit. Findings include: 1. Resident D's clinical record was reviewed on 9/13/22 at 11:48 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety disorder, memory deficit, chronic diastolic heart failure, and muscle weakness. During an interview with Resident D on 9/13/22 at 1:47 p.m., she demonstrated how she pushed her call light pendant to alert staff that she needed assistance by using two index fingers to push down on the button of the pendant. She indicated staff do not like to come in at night and the staff would stand in the hall but no one would come in to help her. At 9/13/22 at 2:07 p.m. staff had not responded to the call button button being pushed at 1:47 p.m. The alert button on her nightstand and the call	R 0027	1. Resident D and other Memory Care residents had no negative affects from alleged deficient practice. 2. All Memory Care residents have the potential to be affected by alleged deficient practice. 3. Audit completed by Maintenance Director on September 28, 2022, to ensure adequate equipment of pendent reset and call phones available for staff. No new equipment needed to be ordered. Resident D has new wrist pendant ordered. Call light reset pendent changed to larger key ring to ensure it stays on Memory Care. Nurse call light report will be pulled daily by Nursing Director and/or designee and be added to the 24-hour report and reviewed each morning during Director's meeting. If call light response is greater than standard response time, nursing director and/or designee will investigate with staff and interview resident to ensure no negative affection occurred. These occurrences will	10/14/2022

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	light in the bathroom were both activated at 2:07 p.m.. Review of Resident D's call light logs from 8/31/22 through 9/14/22 and provided by the sister facility DON on 9/14/22 at 3:56 p.m., indicated, but was not limited to, the following call light activations: On 8/31/22 at 12:57 p.m., the bathroom call light alerted staff 22 times and was responded to at 2:02 p.m. (65 minutes). On 9/2/22 at 1:56 a.m., the bathroom call light alerted staff 31 times and was responded to at 3:27 a.m. (91 minutes). On 9/2/22 at 8:58 p.m., it alerted staff 33 times and was responded to at 10:36 p.m. (98 minutes). On 9/2/22 at 9:24 p.m., the bath room call light alerted staff 24 times and was responded to at 10:34 p.m. (70 minutes). On 9/2/22 at 10:23 p.m., it alerted staff 20 times and was responded to at 11:22 p.m. (59 minutes). On 9/3/22 at 10:49 a.m., it alerted staff 65 times and was responded to at 2:01 p.m. (192 minutes). On 9/4/22 at 12:56 p.m., the bathroom call light alerted staff 60 times and was responded to at 3:54 p.m. (178 minutes). On 9/5/22 at 1:22 a.m., the bathroom call light alerted staff 14 times and was responded to at 2:03 a.m. (41 minutes). On 9/5/22 at 7:09 p.m., the bathroom call light alerted staff 43 times and was responded to at 9:17 p.m. (128 minutes).		be recorded on audit form and reviewed in QA meetings. Nursing Directors will inservice nursing staff on Call light policy and procedure by October 14, 2022. 4. Call light audit report will be reviewed by monthly QA committee and make recommendations for further intervention. This will be added as on-going audit to ensure compliance. 5. October 14, 2022	

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	On 9/6/22 at 4:18 a.m., it alerted staff 56 times and was responded to at 7:05 a.m. (167 minutes). On 9/6/22 at 6:27 p.m., the bathroom call light alerted staff 30 times and was responded to at 7:56 p.m. (89 minutes). On 9/6/22 at 8:36 p.m., the bathroom call light alerted staff 43 times and was responded to at 10:45 p.m. (129 minutes). On 9/7/22 at 6:06 a.m., it alerted staff 19 times and was responded to at 7:01 a.m. (55 minutes). On 9/7/22 at 2:05 p.m., the bath call light alerted staff 78 times and was responded to at 5:57 p.m. (232 minutes). On 9/7/22 at 8:12 p.m., the bathroom call light alerted staff 58 times and was responded to at 11:03 p.m. (171 minutes). On 9/9/22 at 9:43 p.m., it alerted staff 16 times and was responded to at 10:28 p.m. (45 minutes). On 9/11/22 at 7:15 p.m., it alerted staff 38 times and was responded to at 9:07 p.m. (112 minutes). On 9/11/22 at 3:17 p.m., it alerted staff 29 times and was responded to at 4:42 p.m. (85 minutes). On 9/11/22 at 4:46 p.m., the bathroom call light alerted staff 44 times and was responded to at 6:56 p.m. (130 minutes). 2. During the review of the call logs for Resident D, there were other residents in the Memory Care Unit with long response times, which included, but were not limited to, the following:			

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	On 9/2/22 at 10:26 a.m., a call light alerted staff 105 times and was never responded to. On 9/5/22 1:08 p.m., a call light alerted staff 10 times and responded to at 1:36 p.m. (28 minutes). On 9/7/22 at 2:34 p.m., a bathroom call light alerted staff 87 times and was responded to at 6:53 p.m. (259 minutes). On 9/7/22 at 2:39 p.m., a call light alerted staff 67 times and was responded to at 5:58 p.m. (199 minutes). On 9/11/22 at 4:28 a.m., a call light alerted staff 15 times and was responded to at 5:11 a.m. (43 minutes). On 9/12/22 at 5:09 p.m., a call light alerted staff 105 times and the alert was never responded to. On 9/13/22 at 1:48 p.m., a call light alerted staff 18 times and was responded to at 2:39 p.m. (51 minutes). On 9/13/22 at 8:18 p.m., a call light alerted staff 16 times and was responded to at 9:05 p.m. (47 minutes). During an interview with QMA 1 on 9/13/22 at 2:26 p.m., she was sitting down in the chair of the Nurses' Station and her phone was ringing, which meant a call light had been activated. She indicated it was Resident D's call light that was going off and it looked like it had been going off for 40 minutes and she indicated she would go answer it. During an interview with CNA 2 on 9/13/22 at 2:34			

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	p.m., she indicated she did not have her phone on her and she had left the phone on the table with a resident in the common area. During an interview with the DON, on 9/14/22 at 11:07 a.m., she indicated she believed the call lights should have been answered within 12 minutes but would like staff to answer them within 7 minutes when possible. She believed there were three aides and either a QMA or Nurse plus the Memory Care Director to answer the call lights. A policy titled, "Emergency Nurse Call System Policy," provided by the Administrator, on 9/14/22 at 1:08 p.m., indicated the following: "...Responsibility...D. CNA Staff/Nursing Staff will respond to emergency alerts upon activation. Procedure...1. CNA or on call personnel will immediately go to the located alert. Alarm will be reset as soon as possible after emergency is identified...5. Promptness is essential, the Resident may be in an emergency situation such as chest pain, heart attack, difficulty breathing, have fallen, etc...." This state residential finding relates to Complaints IN00389652 and IN00389947.			
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.			

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	Based on record review and interview, the facility failed to ensure the family of a cognitively impaired resident was notified of a decline in the resident's condition including that the resident had been sent to the hospital for evaluation and treatment. (Resident G) Finding includes: The clinical record for Resident G was reviewed on 9/15/2022 at 11:16 a.m. Diagnoses included, but were not limited to, hypertension, gastro-esophageal reflux disease, hypothyroidism, neurocognitive disorder and osteoporosis. The resident lived on a secured memory care unit. During a unit tour on 9/15/2022 at approximately 10:00 a.m., QMA 1 was heard speaking loudly in a distressed voice. The QMA indicated the resident had a pressure ulcer on her bottom and it was getting worse with no interventions from the facility. She indicated the pressure area had been reported to the memory care director, who was no longer working in facility, approximately 2 weeks ago or longer. During an interview on 9/15/2022 at 10:17 am QMA 1 indicated she talked to the DON (Director of Nursing) and the DON had unsuccessfully attempted to contact the home health agency. The QMA indicated the pressure area started out as a "spot" 3 - 5 weeks ago. She indicated she had reported the concern to the memory care director at the time. During a wound observation on 9/15/22 at 10:35 a.m., with DON and 3 EMTs, the resident was lying on her left side propped by a pillows. The resident was unable to assist with turning so the wound could be observed. A brief was in place,	R 0036	1. Resident G was transferred to Skilled Nursing Facility related to need for higher level of Care. 2. Director of Nursing completed audit on October 3, 2022 of documentation to no other residents identified of alleged defiance practice. 3. Staff in-service to be conducted and completed on notification of resident's physician, and legal representative of change of condition including residents sent to hospital by October 14, 2022 by memory care director/designee. Change of condition notification will be added to 24-hour report and reviewed daily by staff nurse, memory care director/designee. 4. Weekly audit will be completed by Memory Care Director and/or designee to ensure proper notifications have occurred for change of condition. Audits will be reviewed at monthly QA meeting. QA committee will review for 6 months to ensure compliance. 5. October 14, 2022	10/14/2022

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	the DON undid the brief and the EMT pulled the brief back. There was no dressing on the resident's coccyx and her coccyx area was open and approximately. the size of my fist or approximately. the size two baseballs side by side with depth. The inside of the wound looked moist was green, yellow and grayish slough. The skin surrounding the wound on the buttocks was scattered with redness from maceration/excoriation and was open. The resident was sent to the hospital for treatment and evaluation. During an interview on 9/15/22 at 11:09 a.m., the POA (Power of Attorney) for Resident G indicated they were never informed by the facility that the resident had a pressure wound. The POA was also unaware the resident had been sent out to the hospital today. They were not aware a home care company had been called for treatment of the resident's wound. During an interview on 9/15/22 at 2:08 p.m., NP 19 indicated she was in the facility on Monday and followed on last Thursday. No one communicated that skilled nursing was not in to see the resident. "We were under the assumption that skilled nursing was already seeing her or had been." No one let them know that home health was not in yet to see her. It would have been the facility's responsibility to notify the family and physician group. The Administrator and the DON were unable to locate any communication documentation from the past memory care director and the home health agency or the resident's POA. No further information was provided.			

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R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation, interview and record review, the facility failed to ensure the state survey binder was updated with past surveys and that it was accessible to residents, visitors and family members. This had the potential to affect all residents residing in the facility. Finding includes: On 9/13/22 at 10:16 a.m., behind the front desk, there was a sign that indicated the state survey results were available for review at the front lobby. The state survey binder was located in the common area to the right of the front desk, on a top shelf to the right of the fireplace. The binder sat with the unmarked spine of the binder towards the common area. On the front of the binder, it indicated the binder contained the survey results, which were not visible walking into the common area. The last survey result was dated 2/2/22. During an interview with the Administrator, on 9/13/22 at 3:51 p.m., she indicated she thought that the last two years of surveys were supposed to be in the survey binder and she was not aware that all surveys including complaints were to be in the binder. She did have all the surveys in her office. She indicated the survey binder had always been kept in the same place and she would make sure the binder was easily accessible to	R 0042	1. All residents have potential to affected by this alleged deficient practice. 2. Receptionist and Directors inservice will be completed by October 14, 2022 by Administrator on Survey Binder regulation. 3. Weekly Audit will be completed by Administrator and/or designee to ensure Survey Binder is in place and up to date. Monthly QA committee will review audits for 6 months to ensure compliance. 4. October 14, 2022	10/14/2022

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	residents including residents in wheelchairs. During an observation with the front desk employee, on 9/15/22 at 4:00 p.m., the measurement from the floor to the bottom of the shelf where the survey binder was located was 76 inches (6 foot 4 inches). She indicated she also thought the survey binder was a little high for residents in wheelchairs, but "that's where they put it" and so she didn't say anything. During an interview with the DON, on 9/14/22 at 2:34 p.m., she indicated they did not have a policy for the survey binder but follow the state guidelines. This state residential finding relates to Complaint IN00389652.			
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (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 record review, observation and interview, the facility failed to prevent neglect of two residents regarding adequate supervision to prevent elopement and the provision of skin care. The facility failed to prevent Resident B, a cognitively impaired resident who resided on the locked Memory Care Unit, from elopement from the facility. The facility also failed to ensure the appropriate care was provided to a cognitively impaired resident (Resident G) for ongoing skin issues resulting in an open pressure wound and the resident being sent to the hospital.	R 0052	1. Resident G has been discharged to Skilled nursing Facility related to need for higher level of care. Resident B continues to reside on Memory Care unit and had no negative effects from deficient practice. 2. All memory care resident had potential to be affected by deficient practice. No other residents identified from documentation audit of 24 hr	10/14/2022

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	Findings include: 1. The clinical record for Resident B was reviewed on 9/13/2022 at 11:12 a.m. Diagnoses included, but were not limited to, dementia, diabetes type 2 with nephropathy, difficulty walking, carotid artery stenosis and chronic kidney disease stage 3. The resident resided on the secured memory care unit. On 9/13/2022 at 11:48 a.m., a security video for 8/10/2022 was reviewed with the Maintenance Director and the Administrator. Resident B was observed ambulating with an unsteady gait through the main lobby and out of the front doors at 9:28 p.m. The resident remained standing just outside the front door and returned to the lobby and sat in a chair. At 9:32 p.m., a staff member was observed approaching the resident and engaged in conversation. The staff member then made a call on a cell phone and remained with the resident until more staff arrived at 9:35 p.m. The resident could be seen being escorted off frame by the staff members. During an interview on 9/13/2022 at 11:48 a.m., the Maintenance Director indicated the front doors were locked at 8:00 p.m. The Maintenance Director was unable to determine why the doors were not locked. The Maintenance Director indicated the facility believed the resident was able to leave the locked memory care unit by pressing on the door until the locks disengaged (a fire safety measure). During an interview on 9/13/2022 at 12:00 p.m., the Receptionist indicated the front doors were locked from 8:00 p.m. to 8:00 a.m. every day.		report sheets in last 30 days. 3. Exit doors assessed for proper function and safety was completed by Maintenance director on September 28, 2022. All staff in-service on securing community doors at 8:00 pm, elopement policy, use of call/door alarm phones will be conducted by Maintenance Director, Administrator, Director of Nursing and Memory Care Director by October 14, 2022. Memory Care Director and/or designee will do daily audits x 2 weeks then weekly x 4 weeks, then monthly x 6 months to ensure staff is carrying and responding to call/door alarm phones during shift. Director will re-educate staff out of compliance. Call light reports will be reviewed daily at Director's meeting to ensure door alarms did not result in resident being off memory care unit. This audit will be on-going to ensure compliance. 2 elopement drills completed on August 24,2022 and September 30, 2022. Monthly Elopement drills will be completed on a on-going basis. Basic wound care supplies ordered by Director of Nursing. Nursing inservice will be completed by Director of Nursing and Memory Care Director on notifying physicians of change in condition and ensuring proper orders are followed through. All new orders will be placed on 24 hr	

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	During an interview on 9/13/2022 at 3:56 p.m., CNA 2 indicated she had been working the evening of 8/10/2022. She indicated another aide had asked her if she had heard the door alarm going off and that Resident B had gotten out of the building. She had not heard the door alarm going off because she had left her phone at the nursing station. CNA 2 indicated the resident used a wheelchair for locomotion but often times will be found holding onto the handrails and ambulating down the hallways. The CNA indicated the resident's gait was unsteady and they were afraid he would fall. During an interview on 9/13/2022 at 4:11 p.m., QMA (Qualified Medication Aide) 6 indicated on 8/10/2022 she had been working on the memory care unit. At approximately 9:00 p.m. the QMA from the assisted living unit called and indicated she had a resident up front. She asked who the resident was and they indicted it was Resident B. QMA 6 indicated the door alarms were sounding when they went to the front of the building to get the resident. The alarms were unable to be heard in the back part of the memory care unit. QMA 6 indicated if the door alarms go off their phones let them know. The QMA indicated they always carry their phone but sometimes they do not always check when the door alarms sound because it could be staff or a family member using the door. During an interview on 9/13/2022 at 4:20 p.m., QMA 5 indicated she was on the second floor nursing station. A CNA told her she saw a resident outside and went to investigate. QMA 5 called QMA 6 and told her about Resident B. QMA 6 came to get the resident. QMA 5 did not know how the resident got out of the secured memory care unit.		sheet and nursing documentation will completed with new orders and follow up to new orders. Resident charts will be placed on “hot rack” until orders are complete, and resident is stable. Memory Care Director will audit new orders, 24hr report sheet and documentation daily x 2 weeks, then 2x/week for 2 weeks, then weekly x 5 months to ensure orders and care are being completed. 4. All Audits will be reviewed in monthly QA meetings. QA committee members will make recommendations if staff is found to out of compliance with carrying call/door alarms phones or orders are not being followed. Audits will be review for minimum of 6 months, QA will make recommendations on need to continue audit. 5. October 14, 2022	

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		A. BUILDING 00 B. WING	09/16/2022

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	During an interview on 9/13/2022 at 4:27 p.m., QMA 4 indicated she had been passing medications on the assisted living unit. "I stood on the second floor and I saw Resident B, he belonged on the memory care unit. They called [QMA 6] and the LPN [first name]. [QMA 6] came out and got him. I did not hear the alarm go off." QMA 4 was not sure if her phone went off because she was busy passing medications. During an interview on 9/13/2022 at 4:36 p.m., CNA 3 indicated she saw the resident go out the front door from the second floor and went to investigate. The CNA called the assisted living QMA who called the memory care QMA who came to get the resident. The CNA indicated the resident was confused but did not appear to be hurt or injured. Review of the facility reportable indicated the incident happened on 8/10/2022 and was not reported until 8/22/2022. The Administrator indicated she had not been aware of the elopement until 8/22/2022 and reported it immediately. 2. The clinical record for Resident G on 9/15/2022 at 11:16 a.m. Diagnoses included, but were not limited to, hypertension, gastroesophageal reflux disease, hypothyroidism, neurocognitive disorder and osteoporosis. The resident lives on a secured memory care unit. During a unit tour on 9/15/2022 at approximately 10:00 a.m., QMA 1 was heard speaking loudly in a distressed voice. The QMA indicated the resident had a pressure ulcer on her bottom and it was getting worse with no interventions from the facility. She indicated the pressure area had been			

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	reported to the memory care director, who was no longer working in the facility, approximately 2 weeks ago or longer. During an interview on 9/15/2022 at 10:17 am QMA 1 indicated she talked to the Director of Nursing (DON) and the DON had unsuccessfully attempted to contact the home health agency. The QMA indicated the pressure area started out as a "spot" 3 - 5 weeks ago. She indicated she had reported the concern to the memory care director at the time. During a wound observation on 9/15/22 at 10:35 a.m., with the DON and 3 EMTs, the resident was lying on her left side propped by a pillows. The resident was unable to assist with turning so the wound could be observed. A brief was in place, the DON undid the brief and the EMT pulled the brief back. There was no dressing on the resident's coccyx and her coccyx area was open and approximately the size of a fist or approximately the size two baseballs side by side with depth. The inside of the wound looked moist with green, yellow and grayish slough. The skin surrounding the wound on the buttocks was scattered with redness from maceration/excoriation and was open. The resident was sent to the hospital for treatment and evaluation. During an interview on at 9/15/22 at 10:48 a.m., the DON indicated that she was unable to stage necrotic tissue and the resident was in need of wound care. She indicated the open area was on the resident's sacrum and looked like it was going to break down soon but didn't know what was under it. She did not know of any treatment that was ordered because the memory care director was supposed have been taking care of it. The			

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	DON believed there was an order out for home health order about two weeks ago. She indicated she did not manage the residents or the care in the memory care unit. During an interview on 9/15/22 at 11:09 a.m., the POA (Power of Attorney) for Resident G indicated they were never informed by the facility that the resident had a pressure wound. The POA was unaware the resident had been sent out to the hospital. The POA indicated they were not aware a home care company had been called. The POA indicated they had been in discussion with the facility about the change in level of care required by the resident and had decided the resident needed to be moved to a skilled facility. During an interview on 9/15/22 at 11:20 a.m., the Administrator indicated as soon as the nurses were aware they should notify the resident's PCP (Primary Care Provider) with med changes, hospital, change of condition. The NP (Nurse Practitioner) from the Physician's group was at the facility this week on 9/14/2022 and on Wednesday this week another NP would be in the facility. During an interview on 9/15/22 at 11:40 a.m., CNA 13 indicated she had the assignment for Resident G. She indicated the wound on the buttocks was oozing yellow/white stuff and was reported to QMA 1, who reported it to the DON. She indicated the wound was worse today than it had been the last time she saw it earlier this week. The last time she worked, she rotated the resident every hour, not every 2, to help her. She was not aware of any other residents with pressure areas on their bottoms. During an interview on 9/15/22 at 11:50 a.m., CNA 14 indicated that she had reported approximately 2			

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	weeks ago two little areas on the resident's buttocks. The CNA indicated they were told to have the resident up in a chair for meals and in bed after meals and turn side to side. She indicated the areas were not open at that time. The wound was worse this week. It was a red dot a couple weeks ago and eventually got worse. During an interview on 9/15/22 at 12:01 p.m., CNA 16 indicated the resident had an area on her buttocks approximately a month ago that looked like a carpet burn, maybe smaller than a dime, and was not open. The skin was intact. Approximately 2 weeks or so ago it had opened. The QMAs tried to do what they could, but no one had a sense of urgency. The QMAs were trying to keep it clean. She was told home care came in this past Monday, but had not seen anyone. She originally reported it when it was a carpet burn and reported it to the NP. During an interview on 9/15/22 at 1:57 p.m., an RN from home care indicated they received an order, dated 8/30/2022, to come out to do start of care. She indicated she was unable to reposition the resident without assistance to assess the wound. She asked staff for assistance and no one came to help her. The CNAs were busy getting residents ready for lunch and asked her to come back after lunch. She indicated due to her schedule, she was unable to return to the facility after lunch and attempted to reposition the resident alone. The home care company had never provided documentation to the facility in the past and communicated through the contracted ST. On 8/30/22, she came in and put calmoseptine lotion on her bottom and ordered alginate. The home health RN described the wound as scattered macerated areas, not a lot of drainage and was opened. The area was scattered on both side of			

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	buttocks. No necrotic or slough was observed to the wound. She had measured as well as she could while holding the resident by herself. Home care was waiting for insurance authorization to begin treatment. She indicated the insurance company for this particular resident could take up to 2 weeks to send the authorization and authorization just came in on 9/14/2022. Review of the home care order, dated 8/30/2022, indicated the primary diagnoses was "unspecified open wound of unspecified buttocks, initial encounter". "Initial orders: Relieved orders 8/30/2022 to eval [evaluate] patient for home health care services. Patient seen by SN [skilled nurse] 8/30/2022. ..." Measurements documented as 2.5 x 0.5 x 0.1. Drainage: amount small. Drainage type: sangulnous [sic]. Drainage color: blood-tinged. Review of the Skilled Nurse Notes for the initial encounter, dated 8/30/2022, indicated the following: "Patient noted to be sitting in recliner with no brief on. Staff unavailable to assist with patient care at this time, SN attempted to roll patient over with difficulty, scattered excoriationed [sic] areas noted, calmoseptine applied. No dressing applied due to no future visits scheduled at this time. This write [sic] left tube of calmoseptine in room for staff use. Waiting on authorization and supplies to be delivered. Will plan to have LPN follow patient due to this writer unavailable to see patient before lunch starts to have staff available to assist with patient stand or turn. Patient alert but not oriented, does not follow simple commands. Becomes agitated during care. (name of ST) notified of staff stating they are unavailable to assist in standing or turning patient due to it being near lunch time and that authorization will			

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	be needed for future visits can be made. Staff to apply calmoseptine as they have been doing until skilled nursing approved to see patient." During an interview on 9/15/22 at 2:08 p.m., NP 19 indicated she was in the facility on Monday and followed on last Thursday. No one had communicated that skilled nursing was not in to see the resident. There was so much barrier cream in her wound area, the wound itself was full of cream, border dressing and so thick. There was also a wipe folded under the foam dressing. "We were under the assumption that skilled nursing was already seeing her or had been.' No one had let them know that home health was not in yet to see her. It would have been the facility's responsibility to notify the family and the physician group. The Administrator and the DON were unable to locate any communication documentation from the past memory care director and the home health agency or the resident's POA. No further information was provided. This state residential finding relates to Complaints IN00389303 and IN00389404.			
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (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 a resident's apartment was cleaned for of 1 of 3 resident's apartment reviewed for cleanliness (Resident D). Finding includes:	R 0144	1. Resident D apartment was thoroughly clean on September 20, 2022 by housekeeping department. Resident D did not show any adverse effects of deficient practice.	10/14/2022

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	Resident D's bathroom was observed on 9/13/22 at 1:36 p.m..There was a brown ring around the toilet bowl where the water line was in the center of the bowl. There was gray scum that covered the bottom of the toilet bowl beneath the water line and scattered specks of brown substance inside the toilet bowl up to and on the seat of the toilet. The bathroom floor had small scattered debris throughout the bathroom. A Residential Service Plan, dated 6/3/22 and provided by a sister facility DON on 9/14/22 at 11:00 a.m., indicated she required full assistance with housekeeping. Her services included, but were not limited to, housekeeping would clean the bathroom, shower and toilet weekly or as needed for sanitation. During an interview with the Maintenance Supervisor, on 9/13/22 at 4:04 p.m., he indicated his Maintenance Assistant helped with housekeeping but quit two weeks ago and before that, it was intermittent. He has had no one for the last two weeks. The CNAs were cleaning the memory care unit. He cleaned the common area during the day. He had received complaints about the rooms not being clean and he asked the complainants to complete a work order and then he took care of it right away. The Cleaning Check-Off List for the 1st floor indicated the last time Resident D's bathroom and apartment was cleaned was on 7/28/22. Housekeeping instructions for nursing staff, dated 8/17/22 and posted in the Nurses' Station, indicated the following: "To ensure apartments remain clean and tidy, the following will happen.		2. All residents have potential to be affected by this alleged deficient practice. No residents showed any adverse effects. 3. Nursing assistant will be assigned a list of cleaning duties for apartments, Resident assistant will use a check off sheet to ensure assigned apartments are clean and tidy. CNA's will be inserviced by the Administrator by October 14, 2022. Directors will audit the Memory Care Apt weekly for cleanliness. 4. Audits will be reviewed by monthly QA committee for 6 months; QA committee will make recommendations as needed. 5. October 14, 2022	

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	1. Memory Care Director or designee will inspect each apartment in the beginning of the shift and the end of the shift. 2. Each Resident Assistant will be assigned a list of cleaning duties. 3. Resident Assistant will sign a check off sheet to ensure assigned apartments are clean and tidy. 4. Resident Assistant will do rounds of the assigned list before the end of the shift. 5. Resident Assistant will give report and do rounds with oncoming shift. Nurse or QMA will be your direct supervisor. Please turn in signed sheets to them." A facility policy, titled "Housekeeping-Supplemental Services," provided by the Administrator as current on 9/15/22 at 1:08 p.m., indicated: "Policy...Housekeeping will be provided at least weekly to provide a clean and safe environment for optimal health...Responsibility: A. It is the responsibility of the certified nursing staff to assist with making beds and keeping resident's bathrooms clean and orders between the weekly housekeeping services...Procedure: A. Apartments will receive at least weekly general housekeeping services, such as vacuuming, dusting, changing of linens, making beds, cleaning restrooms and kitchenettes...." This state residential finding relates to Complaint IN00389947.			
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, interview, and record review, the facility failed to provide and document	R 0240	1. Resident B, D, G were all given showers on next scheduled	10/14/2022

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	showers and ADL (Activities of Daily Living) care for 3 of 3 residents reviewed for ADL care (Residents D, B and G). Findings include: 1. Resident D's clinical record was reviewed on 9/13/22 at 11:48 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety disorder, memory deficit, chronic diastolic heart failure and muscle weakness. Her Residential Service Plan, updated 6/3/22 and provided by the sister facility DON on 9/14/22 at 11:00 a.m., indicated she required hands on assistance with showers. Her services included, but were not limited to, nursing staff would provide hands on assistance with showers once weekly on Thursdays. During an interview with Resident D on 9/13/22 at 1:47 p.m., she indicated she was supposed to receive a shower on Thursdays during the day. She could not remember the last time she had a shower but her daughter had been in last Saturday to shampoo her hair. Assignment Sheet #3 indicated Resident D required assistance with all care. The Shower Sheet indicated she was to receive her showers on Thursdays during the day. At the bottom of the shower sheet, it indicated the shower sheets must be completed and signed by the nurse or QMA. Review of her Task Documentation for July, August and September, 2022 indicated, but was not limited to, the following:		shower day. No adverse effects were noted from alleged deficient practices. 2. All residents on memory care have the potential to be affected by this alleged deficient practice. No residents showed any adverse effects. 3. Shower tasks were reviewed in electronic record and any missing shower tasks were added by nursing director and/or designee. Inservice will be completed by October 14, 2022 by Nursing Director for all nursing staff on use of electronic medical record for identifying daily tasks and documentation of completed/refused tasks. Memory Care Director will audit task documentation daily x 2 weeks, then weekly x 6 months. 4. Audits will be reviewed by monthly QA committee for 6 months; QA committee will make recommendations as needed. 5. October 14, 2022	

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	a. Assist with AM care, hygiene related to cognitive deficit (2:00 p.m. - 10:00 p.m.) AM care was only documented that it was completed on 7/25/22 and 7/30/22 for the month of July. AM care was only documented that it was completed on 8/5/22 for the month of August. AM care was only documented that it was completed on 9/2/22 thus far for the month of September. b. Assist with PM care, hygiene related to cognitive deficit (2:00 p.m. - 10:00 p.m.) July lacked documentation that PM care was completed. PM care was only documented that it was completed on 8/17/22 and 8/27/22 for the month of August. PM care was only documented that it was completed, on 9/3/22 and 9/4/22 thus far for the month of September. c. Assist with showers and wash hair, if she refused to notify the nurse (6:00 a.m. - 2:00 p.m.). A shower and hair wash was only documented that it was completed on 7/25/22 for the month of July. August lacked documentation for showers and hair washing. September lacked documentation for showers and			

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	hair washing. d. Assist with toileting every two hours while awake. Resident wears briefs and is incontinent of bowel and bladder. Encourage proper hygiene, offer assistance (6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m.). Toileting every two hours was only documented that it was completed on 7/25/22 and 7/30/22 for the month of July. Toileting every two hours was only documented that it was completed on 8/5/22, 8/17/22 and 8/27/22 for the month of August. Toileting every two hours was only documented that it was completed on 9/2/22, 9/3/22 and 9/4/22 for the month of September. 2. Resident B's clinical record was reviewed on 9/13/22 at 11:20 a.m. Diagnoses included, but were not limited to, dementia, diabetes type II with neuropathy, difficulty walking, carotid artery stenosis and chronic kidney disease stage III. Assignment Sheet #1 indicated Resident B required assistance with all care. The Shower Sheet indicated he was to receive his showers on Wednesdays and Saturdays in the evening. Review of his Task Documentation for July, August and September, 2022 indicated, but was not limited to the following: a. Assist with AM care, hygiene related to cognitive deficit (2:00 p.m. - 10:00 p.m.)			

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	July AM care was only documented that it was completed on 7/25/22 for the month of July. AM care was only documented that it was completed on 8/5/22, 8/13/22 and 8/19/22 for the month of August. September AM care lacked documentation that it was completed. b. Assist with PM care, hygiene related to cognitive deficit (2:00 p.m. - 10:00 p.m.) July lacked documentation that PM care was completed. PM care was only documented that it was completed on 8/12/22, 8/24/22, 8/26/22 and 8/27/22 for the month of August. PM care was only documented that it was completed on 9/5/22 for the month of September. c. Moderate assistance with showers, Please wash hair and shave on shower days. (6:00 a.m. - 2:00 p.m.). A shower, hair wash and shave was only documented that it was completed on 7/25/22 for the 6:00 a.m. - 2:00 p.m. shift for the month of July. August lacked documentation for showers, hair washing and shave. September lacked documentation for showers, hair washing and shave. d. Assist with toileting every two hours while awake. Resident wears briefs and is incontinent of			

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		A. BUILDING 00 B. WING	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	bowel and bladder. Encourage proper hygiene, offer assistance (6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m.). Toileting every two hours was only documented that it was completed on 7/25/22 for the 6:00 a.m. - 2:00 p.m. shift and lacked documentation that toileting every two hours was completed for the 2:00 p.m. - 10:00 p.m. shift for the month of July. Toileting every two hours was only documented that it was completed on 8/5/22, 8/13/22 and 8/19/22 for the 6:00 a.m. - 2:00 p.m. shift; completed on 8/12/22, 8/24/22, 8/26/22 and 8/27/22 for the 2:00 p.m. - 10:00 p.m. shift; and lacked documentation that the resident was toileted every two hours while awake for the 10:00 p.m. - 6:00 a.m. shift for the month of August. Toileting every two hours lacked documentation that it was completed for the 6:00 a.m. - 2:00 p.m. shift and was only documented that it was completed on 9/5/22 for the 2:00 p.m. - 10:00 p.m. shift for the month of September. 3. Resident G's clinical record was reviewed on 9/15/22 at 11:16 a.m. Diagnoses included, but were not limited to, memory loss, neurocognitive disorder and seizure disorder. Assignment Sheet #3 indicated Resident G needed all care provided to her. The Shower Sheet indicated she was to receive her showers, on Tuesday and Fridays, during the day. Review of her Task Documentation for July, August and September, 2022 indicated, but was			

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	not limited to, the following: a. Assist with AM care, hygiene related to cognitive deficit (2:00 p.m. - 10:00 p.m.) AM care was only documented that it was completed on 7/25/22, 7/26/22, 7/27/22 and 7/30/22 for the month of July. AM care was only documented that it was completed on 8/13/22 for the month of August. AM care was only documented completed on 9/2/2 for the month of September. b. Assist with PM care, hygiene related to cognitive deficit (2:00 p.m. - 10:00 p.m.) July lacked documentation that PM care was completed. PM care was only documented that it was completed on 8/27/22 for the month of August. PM care was only documented that it was complete on 9/4/22 for the month of September. c. Assist with showers and wash hair, if she refused to notify the nurse (6:00 a.m. - 2:00 p.m.). July lacked documentation for showers or hair washing. August lacked documentation for showers or hair washing. September lacked documentation for showers or hair washing. d. Assist with toileting every two hours while			

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	awake. Resident wears briefs and is incontinent of bowel and bladder. Encourage proper hygiene, offer assistance (6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m.). Toileting every two hours was only documented completed on 7/25/22, 7/26/22, 7/27/22 and 7/30/22 for the month of July. Toileting every two hours was only documented complete on 8/13/22 and 8/27/22 for the month of August. Toileting every two hours was only documented completed on 9/2/22 and 9/4/22 for the month of September. During an interview with QMA 6, on 9/13/22 at 4:20 p.m., she indicated if they are not adequately staffed they struggle and showers are not always able to be done. In the last week or so they have been staffed ok, but before that they were not staffed adequately. They had two CNAs with a nurse or a QMA for 30 residents. During an interview with CNA 8, on 9/14/22 at 9:55 a.m., she provided a blank shower sheet and indicated she was unable to find the binder in the CNA nurses station. She indicated they would give the shower, complete the shower sheet, turn it into the QMA or LPN and they sign off on it. They do not document it in the electronic health record. During an interview with QMA 1, on 9/14/22 at 9:58 a.m., she indicated the completed shower sheets were located in the binder and she was unable to find the binder. She looked in both Nurses' Stations and was unable to locate them. She indicated the previous director may have			

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	pulled them. During an interview with QMA 1, on 9/14/22 at 11:34 a.m., she indicated agency CNAs were not signing off on the CNA charting because they told her that they did not have access to the computers. During an interview with the sister facility DON, on 9/14/22 at 12:56 p.m., she indicated the CNA should be documenting in the Tasks and they were not completed. During an interview with the DON on 9/14/22 at 3:56 p.m., she indicated they did not have a policy on CNA documentation. This state residential finding relates to Complaints IN00389303 and IN00389947.			