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	08/04/2023

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 a State Residential Licensure Survey. Survey dates: August 3 and 4, 2023 Facility number: 014213 Residential Census: 119 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 10, 2023.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu of a Post Survey Review.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, record review, and interview, the facility failed to ensure exit doors on a locked dementia unit were kept locked and	R 0148	**1. What Corrective action(s) will be accomplished for those residents found to have been**	09/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charles Boswell	Regional Director of Operations	08/25/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	alarmed for 4 of 4 doors that exited to the courtyard. Findings include: During an observation, on 8/3/23 at 10:40 a.m., the exit door in the Sun Room that led to the courtyard had a sign that indicated "For residents safety, all doors to the courtyard will remain secured and alarmed, for access, please see one of our staff for assistance." The door was able to be opened, no alarm sounded, and no staff responded to the area. During an observation, on 8/3/23 at 10:44 a.m., the exit door in Living Room 2 that led to the courtyard had a sign that indicated "For residents safety, all doors to the courtyard will remain secured and alarmed, for access, please see one of our staff for assistance." The door was able to be opened, no alarm sounded, and no staff responded to the area. During an observation, on 8/3/23 at 10:46 a.m., the exit door in Living Room 1 that led to the courtyard had a sign that indicated "For residents safety, all doors to the courtyard will remain secured and alarmed, for access, please see one of our staff for assistance." The door was able to be opened, no alarm sounded, and no staff responded to the area. During a meal observation, on 8/3/23 at 11:53 a.m., two residents exited out of Living Room 2 door into the courtyard. They walked with seated, four-wheeled walkers. No alarm sounded. During an interview, on 8/4/23 at 8:54 a.m., QMA 7 indicated they used a phone system for notifications. If a resident pushed their call		**affected by the deficient practice** a. No residents were adversely affected. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All White Oaks Memory Care residents had the potential to be affected. No memory care residents were adversely affected. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. Memory Care Courtyard door policy developed i. All Current Staff will be educated on memory care courtyard door policy ii. Memory care courtyard door policy will be incorporated into general orientation. iii. Education to be presented to family members and responsible parties via Care Merge **4. How the corrective action(s) will be monitored to ensure the deficient practice**	

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	pendent, a notification was sent to the phone. If someone entered onto the secure unit or exited from the secure unit, a notification was sent to the phone. The courtyard doors were not set up to send notifications to the phone. During the interview, the Living Room 1 exit door that led to the courtyard was opened and no alarm sounded. During an interview, on 8/4/23 at 10:07 a.m., CNA 5 indicated residents were allowed to go into the courtyard but a staff member needed to be with them. The doors were locked at night and unlocked in the morning. During an interview, on 8/4/23 at 10:13 a.m., CNA 12 indicated the doors to the courtyard were locked between 8:00 p.m. to 8:00 a.m. An alarm sounded if a resident tried to open a door to the courtyard. During an interview, on 8/4/23 at 10:16 a.m., CNA 9 indicated doors to the courtyard had an alarm to alert staff if a resident exited. During an observation of the Activity Room, accompanied by CNA 9, the door that exited to courtyard was not locked and no alarm sounded when door was opened. During an observation, accompanied by LPN 3 on 8/4/23 at 10:27 a.m., the Sun Room exit door to the courtyard was not locked and no alarm sounded when door was opened. During an interview, on 8/4/23 at 10:32 a.m., The Maintenance Director indicated the exit doors to the courtyard were to be armed and locked when not in use. Review of a current facility policy titled, "Admission Criteria," with a last revised date of		**will not recur, i.e what quality assurance program will be put into place:** a. All four White Oaks Memory Care courtyard exit doors will be checked twice daily for lock and alarm unless staff are outside with resident (s) two times daily for 4 weeks; then 2 times a day 4 times a week for 4 weeks; then 2 times a day 2 times a week for 2 weeks; then checks ongoing as needed **5. By what date will the systematic changes be completed**: 9/15/23	

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	8/2017 and provided by the DON on 8/4/23 at 3:45 p.m., indicated the following: "...Prospective residents for the memory care community will be evaluated for appropriateness prior to move in. In addition, residents admitted will meet the the following criteria: 1. Diagnosis of Alzheimer's disease or related irreversible dementia. 2. Primary need for care and supervision are due to dementia and/or behavioral issues...6. Determined to be manageable within the physical environment and operational structure...." During an interview, on 8/4/23 at 3:48 p.m., the Administrator indicated they did not have policy related to the secure unit and exit doors and orientation education did not include secure unit and exit doors.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and and interview, the facility failed to implement an infection control program to analyze patterns of known infectious symptoms. This deficient practice had the potential to impact 119 of 119 residents. Findings include:	R 0407	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. May infection control log analysis completed, upon review 5	09/15/2023

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	During record review on 8/4/23 at 3:02 p.m., the infection control resident log for May 2023 indicated 11 residents had symptoms documented as upper respiratory infection (URI): a. Residents on the fourth floor were with URI symptoms starting on 5/2/23, 5/5/23, and 5/6/23. b. Residents on the third floor were with URI symptoms starting on 5/4/23 and 5/5/23. c. Residents on the second floor were with URI symptoms 5/9/23, 5/10/23, and 5/12/23. The log contained no infection analysis, tracking or trending information, or COVID-19 testing. During record review on 8/4/23 at 3:02 p.m., the infection control resident log for June 2023 indicated 50 residents were prescribed an antibiotic medication. The log contained symptoms for 16 of the 50 residents listed. The log contained no symptoms, infection analysis, tracking or trending information, or COVID-19 testing. During an interview, on 8/4/23 at 3:05 p.m., the DON indicated she had not updated the Infection Prevention binder to include the areas she intended to follow such as mapping locations for communicable infections. The months in question were prior to her being hired. The policy the facility used for infection control was the "COVID-19 Infection Control Policy." During an interview, on 8/4/23 at 3:45 p.m., QMA 2 indicated when a resident showed new respiratory symptoms she would obtain vitals, report to the scheduled floor nurse, and send a message to the DON immediately.		residents noted to have URI (duplicate entries noted). Residents' information was added to floor plans, tracking and trending reviewed no common issues found except husband/wife both had UTI and share apt. June and July infection control logs analysis completed and found no residents affected by alleged deficient practice. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All 119 residents have potential to be affected by alleged deficient practice. No residents were found to be affected by alleged deficient practice. 3. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. Director of Nurse will be completing monthly log, analysis, tracking and trending. COVID policy and procedure review with Director of Nursing by the Regional Director of Clinical services on August 22,2023. Director of Nursing inserviced nursing staff on Infection Control Program on August 22, 2023. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality**	

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	Review of a current facility policy, titled, "COVID-19 Infection Control Policy", last revised 11/18/22 and provided by the DON on 8/4/23 at 3:45 p.m., indicated the following: "... Residents are encouraged to report any signs or symptoms of COVID-19 or other illness to a staff member right away. ...Residents with close contact exposure should have daily wellness screening and vital signs for 10 days. ...Isolation Precautions: ...For residents with suspected and/or confirmed COVID-19. This isolation precaution type will be implemented immediately for the care of residents with suspected and/or confirmed COVID-19, as recommended by the CDC...."		**assurance program will be put into place:** a. The QAPI committee will review Infection Control Program monthly information and make recommendations if needed. Infection Control Program will remain a monthly Key Performance area x 6 months to ensure analysis of Infection Control Program is being adequately evaluated. **5. By what date will the systematic changes be completed**: 9/15/23	