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	02/02/2024

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 IN00426672 and IN00425749. Complaint IN00426672 - State deficiencies related to the allegations are cited at R0052. Complaint IN00425749 - State deficiencies related to the allegations are cited at R0297. Survey date: February 1 and 2, 2024 Facility number: 014213 Residential Census: 119 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 6, 2024.	R 0000		
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 observation, interview and record review the facility failed to ensure residents were free from neglect as evidenced by lack of supervision to prevent elopement of a cognitively impaired resident from a secured unit (Resident E), lack of supervision to prevent the elopement of a resident experiencing a cognitive decline with an increased elopement risk (Resident D), and failed	R 0052	**The corrective action that will be accomplished for those residents found to have been affected by the alleged deficient practice:** A) Resident E was affected. No adverse occurrences noted. The resident was immediately assessed with	03/02/2024

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

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	to develop and implement a supervision and/or safety plan for a resident admitted to the facility with an identified elopement risk and need to reside on the secured unit who was residing in the assisted living area (Resident B) for 3 of 3 residents reviewed for elopement risk. Findings include: 1. Review of a 1/26/24 facility self-reported incident report indicated on 1/25/2024, a memory care assisted living resident was escorted back into the secure unit by staff after they were found walking on the sidewalk near the memory care entrance. Review of a 1/26/24 facility document titled, "Investigation Summary", indicated the timeline of events included Resident E being seen seen by the Memory Care Director at 8:55 a.m. in the piano room. The resident was encouraged to attend an activity at 9:30 a.m. They were next redirected into the White Oaks entrance at 9:45 a.m. by an LPN returning from break. All exit doors were tested and in proper order. Review of a 1/26/24 facility document titled, "Investigation Summary", indicated staff interviews determined the Memory Care Director observed Resident E sitting in the piano room prior to attending morning meeting at 9:00 a.m. A second staff member observed the resident sitting in the piano room and asked if he wished to attend a movie they were beginning in another area of memory care. The resident declined. The DON completed interviews promptly with all staff on shift and determined that a CNA had exited for break at 9:30 a.m. from the White Oaks entrance and Resident E observed her leave and followed her.		no concerns noted. Service plan updated to include additional care instructions and increased supervision to prevent elopement from a secure AL memory care unit. B) Resident D was affected. No adverse occurrences noted. The resident was immediately assessed with no concerns noted. The resident was transferred 1/19/2024 from unsecure AL to secure AL memory care unit. Service plan updated to include additional care instructions and preventative elopement measures. C)Resident B was not affected. No adverse occurrences noted. The resident was assessed upon admission with no concerns noted. Service plan updated to include additional care instructions and preventative elopement measures. The resident was transferred 2/14/2024 from unsecure AL to secure AL memory care unit. **How the facility will identify other residents having the potential to be affected by the alleged deficient practice and the corrective action that will be taken;** All AL and AL memory care residents who experience a cognitive decline and are independently mobile have the potential to be affected by alleged deficient practice. **The measures put in place and systemic changes the facility will make to ensure that the**	

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	The 1/26/2024 incident report file lacked the completed employee interviews. Resident E's clinical record was reviewed on 2/2/24 at 9:15 a.m. Diagnoses included atrial fibrillation, sleep apnea, and dementia. The resident resided on a secured memory care unit. A 11/2/23, Saint Louis University Mental Status (SLUMS) assessment tool (a tool to quickly assess cognitive functions) scored Resident E as 6 out of 30. This scoring tool indicated the outcome as dementia. A 12/5/23, "Elopement Risk Evaluation", indicated Resident E had high risk factors such as disoriented to time and place. The evaluation placed Resident E at high risk for elopement and recommended a secure memory care neighborhood. A 12/4/23, "Level of Service Assessment/Evaluation," indicated the residents decisions were poor, they required cueing and supervision in planning, organizing and correcting daily routines. They were independent with mobility. A Nurse's Note, dated 1/25/24 at 12:15 p.m., indicated the resident was found on the sidewalk outside the memory care exit doors by staff nurse entering the building. He was fully dressed, with long sleeves, and had proper shoes/footwear on. The outside temperature was cool, but not cold. He showed no signs of being cold (such as shivering, cold hands) when brought back into the building and no signs of distress. During an observation, on 2/1/24 at 11:20 a.m.,		**alleged deficient practice does not recur;** A) DON or designee will review nurses notes daily and update Service Plan, area of additional care instructions, to include a comprehensive safety service plan and initiate safe discharge procedures if resident is identified to be of danger to themselves or to others. B) ED or designee will educate all staff upon hire and annually regarding the potential for the time delay on the lock mechanism of each door on the secure AL memory care unit. C) DON or designee will complete a comprehensive safety service plan for all resident SLUMS assessment/Level of Service/clinical note(s) which indicate a decline in cognitive function and are independently mobile in addition to, the current elopement risk assessment procedure; elopement risk assessment will be completed within 30 days prior to admission, annually and or/upon changes to resident cognition…) Inservice provided 2/28/2024 for all staff to include: recognizing and reporting change in cognition, signs and symptoms of hazardous wandering, understanding and implementing resident service plans and the potential for the time delay on the lock mechanism of each door on the secure AL memory care unit. **The corrective action will be**	

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	Resident E was observed sitting at the dining room table, fully dressed with shoes on. Resident E was talking with other residents seated at table and interacted with staff. During an interview, on 2/2/24 at 10:24 a.m., LPN 3 indicated she was the staff member who found Resident E outside last week. Resident E was confused and said he was cold. Upon entering the building she did an assessment, notified the DON, and asked how the resident had gotten outside, but the resident was unable to answer. She indicated the resident sometimes wandered around but preferred to walk around the unit with another resident. The nurse was not aware if the memory care doors had a delay before the lock mechanism re-engaged. During an interview, on 2/2/24 at 10:45 a.m., QMA 4 indicated she was on shift the day Resident E left the building. She was getting medications prepared when another staff member told her what had happened. She worked on the memory care unit often and Resident E was very mobile, liked to interact with the other residents and sometimes came to the medication window to talk. The resident only mentioned going home when he was bored. She did not remember times when Resident E would linger at exit doors or push on the exit doors. She was aware the exit doors had a delay on the lock mechanism, but since she worked on the memory care unit, she was sure to pay attention to her surroundings when exiting. During an interview, on 2/2/24 at 12:00 p.m., the Maintenance Director indicated the doors utilized a code system for entering or exiting. This type of system required a delay to allow for staff or visitors the time to get inside or outside prior to the alarm sounding. He indicated this time had		**monitored to ensure the alleged deficient practice will not recur;** As a measure of ongoing compliance, the monthly QA committee will review A) the DON or designee audit of nurses notes and updates to service plan daily for 2 weeks, then 4x weekly for 2 weeks, then 1x weekly for 4 weeks, and 4x monthly for 3 months. B) the ED or designee audit of 5 current AL resident with SLUMS of 20 or below and 5 secure memory care unit residents 1x weekly for 4 weeks, then 1x every other week for 2 months, and then x1 monthly for 3 months. C) ED or designee will review observation of staff entering and exiting the memory care unit daily for 2 weeks, then 4x weekly for 2 weeks, then 1x weekly for 4 weeks, and 4x monthly for 3 months. **The date the systemic changes will be completed; March 2, 2024.**	

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	been disclosed to all staff and training was provided. The time delay on the lock mechanism was 8-10 seconds. During an interview, on 2/2/24 at 12:45 p.m., the Administrator indicated she was not at the facility when Resident E was found outside. There was no camera available to review footage, and the DON had done staff interviews immediately. She thought the staff knew the lock mechanisms on the doors had a delay, but this was not covered in orientation or during in-services. An elopement drill was conducted in December 2023. A current facility policy, last reviewed 11/2023, titled, "Elopement Risk and Missing Resident Policy", provided by the DON, on 2/2/24 at 9:21 a.m., indicated the following: "...Guidelines...2. Door alarm checks will be scheduled by maintenance/designee and documented. 3. Staff to be educated upon hire and annually regarding Elopement/Missing Resident process." 2. Review of a 1/19/2024, facility self reported incident report indicated an assisted living resident exited from the main lobby door to retrieve items from her car. The resident was unable to recall how to reenter the building after hours. A 1/19/2024, written statement by QMA 6 indicated around 12:15 a.m., QMA 6 entered the assisted living main entrance and saw Resident D stuck in the foyer, dressed in her pajamas. Resident D indicated she was trying to get items from her car. QMA 6 was able to assist Resident D into the facility, onto the elevator, and into Resident D's apartment. A 1/19/24, facility "Investigation Summary"			

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	document indicated on 1/19/24, the DON notified the Administrator of the incident, who reviewed the surveillance recording immediately. Surveillance showed Resident D exiting from the main lobby door at 12:09 a.m. At 12:11 a.m., surveillance shows Resident D returning to breezeway and standing at the door. At this hour, the door was keypad entry only. There was a call box located to her left, but Resident D showed no signs of using the device. Resident D exited a second time at 12:14 a.m. and returned at 12:17 a.m. At 12:19 a.m., Resident D was standing at the front door, inside the breezeway, when QMA 6 entered into the breezeway and used key pad, escorting Resident D into the building. Resident D's clinical record was reviewed on 2/1/24 at 1:22 p.m. Diagnoses included dementia in other diseases classified elsewhere without behavior and other symptoms and signs involving cognitive functions and awareness. The resident resided in the assisted living apartments. A 12/28/22, "Level of Service Assessment/Evaluation," indicated the resident was oriented to person, place, and time or was sufficiently oriented to functions independently if in familiar surroundings. An annual 6/8/22, "Resident Service Plan," indicated Resident D needed redirection as needed if confusion continued. An "Elopement Risk Assessment" would be completed by a clinician and noted in the resident's medical record. A 1/22/23, SLUMS assessment tool scored Resident D as 17 out of 30. This scoring tool indicated the outcome as dementia.			

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	A 3/31/23, "Level of Service Assessment/Evaluation" indicated the resident was always disoriented and made poor decisions. An updated 6/6/23, "Resident Service Plan" indicated the resident needed redirection as needed if confusion continued. An "Elopement Risk Assessment" would be completed by a clinician and noted in the resident's medical record. A 10/27/23, SLUMS assessment tool scored Resident D as 11 out of 30. This scoring tool indicated the outcome as dementia. A 10/27/23, "Elopement Risk Assessment" document indicated Resident D had a diagnosis of dementia, ambulated independently, wandering behavior was a pattern or tied to the residents past, was cognitively impaired, verbally expressed a desire to go home, packed bags or stayed near an exit door, and wandered without a sense of purpose. The risk assessment scored Resident D at risk for elopement and required delayed egress as a safety intervention. A 1/15/24, SLUMS assessment tool scored Resident D as 4 out of 30. This scoring tool indicated the outcome as dementia. During an observation, on 2/1/24 at 11:15 a.m., Resident D was observed seated in the dining room, interacting with other residents and staff. The resident was fully dressed with a rollator next to the table. During an interview, on 2/2/24 at 11:50 a.m., the DON indicated when a resident had a change in cognition level on the "Level of Service Assessment", then the facility would do a safety			

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	assessment, review the service plan, and discuss the resident changes in the morning "Acuity Meeting". This meeting was an interdepartmental clinical discussion. She would not automatically do an elopement evaluation and she did not review this resident's 3/31/23 "Level of Service Assessment/Evaluation". The DON did not agree the resident was always confused, and felt the resident had the appropriate tools to succeed in a familiar setting, such as the assisted living community. During an interview, on 2/2/24 at 12:53 p.m., the Administrator indicated Resident D had not had issues with returning to the building, but had previously not gone outside at night. The resident's family had left her car parked in the parking lot for a significant time period and this was what prompted the resident to leave the building at midnight in her pajamas. The Administrator indicated Resident D had said, "I have stuff in my car I need to get". The Administrator indicated the front doors lock at 8:00 p.m. and either the key code was required or the visitor used the call box for entrance. During an interview on 2/2/24 at 12:00 p.m. the Maintenance Director, indicated the doors have always had a delay, due to the use of codes and the need to for people to enter code, pass through, and close door. The door is at 8-10 second delay. All staff were informed and advised of this and to watch their surroundings at the doorways. A current facility policy, last reviewed 11/2023, titled, "Elopement Risk and Missing Resident Policy", provided by the DON, on 2/2/24 at 9:21 a.m., indicated the following: "Purpose: As a community the goal is to provide a safe			

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	environment for all residents. A resident Elopement risk assessment will be completed within 90 days prior to admission, quarterly, and/or upon changes to resident level of service..."3. Confidential interviews were conducted during the survey. During a confidential resident interview, a concern regarding resident elopement was made of another resident who was recently admitted with dementia, Resident B. The resident was supposed to live in the secured dementia unit, but there was no room on the unit. Staff were supposed to walk her to and from meals, as she lived on the third floor and could have difficulty finding her room. The other day, she got up from the table to leave the dining room after she finished eating. There were no CNAs in the area. The other residents encouraged her to sit down and wait until the CNAs arrived. It took some talking, but she sat down. The CNAs took a significant amount of time to arrive. Dietary staff were in and out of the area providing the meal, and were not supervising the resident. During an interview on 2/1/24 at 3:08 p.m., Resident B's family indicated their family member had significant dementia, with periods of confusion. The family had completed the pre-admission process with the resident being accepted for admission to the secured dementia unit. The resident had been assigned a room and admission was scheduled. The family was then informed, due to an emergent need, the room had been assigned to a resident who was an elopement risk. The resident would be admitted to the assisted living area of the facility until a room on the dementia unit became open. The resident could get turned around in the building due to the size and multiple floors. The facility assured the			

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	family the resident's needs could be met on the assisted living portion of the facility. Resident B's clinical record was reviewed on 2/1/24 at 11:46 a.m. Current diagnoses included Alzheimer's disease, depression, and hypothyroidism. The resident had a 1/30/24, SLUMS assessment indicated the resident had dementia. The resident was unable to state the day of the week, year, state, remember three words, complete a math problem, name animals, remember a series of numbers, write numbers on a clock, and answered on question correctly about a story that was read to her. A 1/29/24 "Standardized Interview/Initial Assessment", completed by the DON, indicated the resident had dementia, depression, and Slums score of 5 (which indicated dementia). Review of "Clinical Notes" regarding the residents abilities and cognitive status included the following: A 1/30/24 at 1:24 p.m., note indicated the resident was alert and oriented to self only and very hard of hearing. A 1/30/24 at 11:44 p.m., note indicated the resident was ambulatory with a rolling walker and had a slow, steady gait. A 1/31/24 at 10:30 a.m., note indicated the resident was alert and oriented to self and was independently walking in her room without her rolling walker. A 1/21/24 "Elopement Risk Assessment",			

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	completed by the DON, indicated the resident was oriented to time and place, which altered the final score by 16 points. The assessment indicated the resident did not demonstrate "intermittent confusion." If chosen, this selection would add 16 points to the resident's final score. The only selections on the elopement evaluation were Alzheimer's disease diagnosis, depression diagnosis, and reduced mobility. This resulted in a score of 9, which reflected a moderate risk for elopement. If the confusion and disorientation to time and place had either one been selected it would have given the resident a score of greater than 16, which indicated "High Risk" with a recommendation to move to the secure memory care unit. The resident's 1/29/24, "Initial Service Plan" contained topics and pre-listed choices which were chosen as answers by the person completing the assessment. The assessment indicated the resident used a rollator, required an escort to meals, was alert only to self and was forgetful, and was on the "memory care" waiting list. Under the area of additional care instruction, no additional safety/security plan was added to ensure the resident's over all safety or prevent elopement while awaiting a room on the memory care unit. During an interview on 2/2/24 at 10:31 a.m., the Administrator indicated she was unaware of Resident B having any individualized plan for safety and elopement prevention. The resident was escorted to meals and had a daily wellness check. A Slums of 5 was very low and would mean the resident had advanced dementia. During an interview on 2/2/24 at 10:36 p.m., the DON indicated she had not used the SLUMs score of 5 or the resident being alert and oriented			

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	times one when completing the 1/31/24 Elopement Risk Assessment. She did not think the resident would purposefully exit seek. She had not developed a security or safety plan for this resident awaiting placement on a secured dementia unit. The resident could get lost or turned around if out of her room without staff. During an interview, on 2/2/24 at 10:52 a.m., Resident B indicated she knew her name, but did not know the day/date or year, did not know her home town, and knew she was "new here". During a confidential interview, they indicated the facility admitted residents to the assisted living area of the facility who were very confused. There had been a couple of resident elopements. The residents may have resided on the fourth floor. These residents were now currently residing in the secured unit. A current facility policy, with an effective date of 1/2022, titled "Resident's Personal Rights Policy and Procedure," provided by the Administrator on 2/2/24 at 9:47 a.m., indicated the following: "...Each resident shall have the right to: 1. Be free from mental, emotional, social, and physical abuse and neglect and exploitations...." A current facility policy, with an effective date of 1/2022, titled "Residency Admission and Tenancy Requirement," provided by the DON on 2/2/24 at 9:21 a.m., indicated the following: "...Each resident must be capable of self-preservation and independent daily living with assistance; ... As required under the 410 IAC 16.2.5.05(f)(1-5), the Resident must be discharge if the resident: 1. is a danger to the resident or others: ... To ensure the welfare and safety of our potential residents/current residents, we must provide			

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	services only within the limitations of the Scope of Residential Care. Our continued nursing evaluations and comprehensive nursing process will guaranteed that each Resident's services are in compliance with the Residential Regulations 410 IAC 16.2-5...." This citation relates to Complaint IN00426672.			
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, interview, and record review, the facility failed to secure medications administered by the facility and failed to ensure the facility-provided cabinets used by residents who self -administered medications were secure for 39 of 39 residents who self-administered medications, resulting in 10 missing pills for 1 of 1 resident who reported missing medication (Resident C). Findings include: Review of a 1/8/24 facility incident report indicated Resident D reported an identified individual used keys, entered her room, and removed a strip of 10 hypnotic pills (Belsomar) from the locked medication cabinet. During the course of the investigation, residents in the facility indicated a person could pop the lock of the facility's built-in medication cabinet using a butter knife or mail box key.	R 0297	**The corrective action that will be accomplished for those residents found to have been affected by the alleged deficient practice:** A) Resident D was affected. No adverse occurrences noted. The resident was immediately assessed with no concerns noted. Missing medication replaced. A lockbox was provided on 1/8/2024. Cabinet lock replaced on 2/2/2024. **How the facility will identify other residents having the potential to be affected by the alleged deficient practice and the corrective action that will be taken;** All residents whose medication is not stored in a secured medication cabinet have the potential to be affected by alleged deficient practice.	03/02/2024

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		A. BUILDING 00 B. WING	02/02/2024

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	During an interview on 2/1/24 at 10:31 a.m., Resident D indicated, while she was sleeping, an unknown individual entered her room and opened her medication cabinet. Because she was visually impaired, she could not identify the individual. She was very tired when this occurred and did not think about checking her pills until the next morning. When she checked the next morning, one strip of her sleeping medication was missing. She reported her concern to leadership and they completed an investigation. During an observation on 2/1/24 at 10:31 a.m., Resident D's room had a medication cabinet located above the microwave. The cabinet had a lock which resembled the lock on a medal file cabinet. During an interview on 2/1/24 at 2:28 p.m., the Administrator indicated Resident D had stated a person could pop open the medication storage cabinet with a butter knife. During an interview on 2/1/24 at 2:31 p.m., the DON indicated Resident D had indicated the medication storage cabinet could be opened with a butter knife. During the investigation, other residents also made the same statement about the butter knife and also indicated you could open the cabinet with the residents' mail box key. While investigating the allegation, facility staff did open Resident D's medication storage cabinet with a butter knife. With the exception of controlled medications, all medication administered by the facility in the assisted living area of the facility was stored in the same locked cabinet in each individual resident room. The lock on the cabinet resembled a file cabinet lock. Residents who self-administered medication were provided keys and could store their medication in the same		**The measures put in place and systemic changes the facility will make to ensure that the alleged deficient practice does not recur;** A) DON or designee will complete medication audits for residents who self-administer medication and for residents whom the facility administers medication. B) ED or designee will audit medication cabinets in each resident room to ensure each cabinet is secure. C) Inservice provided 2/28/2024 for all staff to include: recognizing and reporting abuse, medication management administration & storage, and the procedure for maintenance requests. **The corrective action will be monitored to ensure the alleged deficient practe will not recur;** As a measure of ongoing compliance, the monthly QA committee will review A) the DON or designee audit for 5 residents who self-administer medication and 5 resident whom the facility administers medication 1x weekly for 4 weeks, then 1x every other week for 2 months, and then x1 monthly for 3 months. B) the ED or designee audit of secure medication cabinets of 5 residents who self-administer medication and 5 resident whom the facility administers medication 1x weekly for 4 weeks, then 1x every other week for 2 months, and then x1 monthly for 3 months.	

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	locked cabinets in their individual resident rooms. The facility was unable to determine the whereabouts of Resident D's missing medications. After determining Resident D was missing medication, and the lock of the mediation storage unit could at times be opened with a butter knife, the facility had not completed medication audits for residents who self-administered medication, or residents for whom the facility administered medication. The facility had not completed an audit to ensure the medication cabinets in each resident room were secured and could not be easily opened with a butter knife, mailbox key, or other like device. During an interview on 2/2/24 at 12:00 p.m., the Maintenance Director indicated he was made aware last night of the butter knife being used to pop open the medication cabinet door. He had spent a lot of time and effort on the medication cabinets over the past five year. He did get work orders to look at the medication doors, as it was an 'off and on' issue. He had made suggestions for alternatives and advised management/staff to remember they weren't dead bolt locks and were easier to manipulate. He had seen evidence of manipulation of locks on the cabinets. A current facility policy, with an effective date of 1/2024, titled "Medication Management, Administration, & Storage (Indiana and Ohio Only)," provided by the DON on 2/2/24 at 9:21 a.m., indicated the following: "...Purpose: The purpose of this policy is to ensure the resident safety is maintained when managing, preparing, administering, and storing all medications while complying with state and federal guidelines. The Community will have available, on the premises or on call, the services of a licensed nurse at all times. ... A 2. If a resident is assessed ass Needing		**The date the systemic changes will be completed; March 2, 2024**	

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	Assistance with Medication Administration, it is the responsibility of the licensed nurse or Qualified Medication Aide (QMA) to administer the medications to the resident.... B. Medication Administration: Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA....C. Storage of Medications: 1. It is the responsibility of all authorized healthcare professionals to ensure the medications are appropriately secured at all times except when authorized personnel are present...." This citation is relates to Complaint IN00425749.			