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

FORM APPROVED
OMB NO. 0938-039

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	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE ASSISTED LIVING OF YORKTOWN	1400 S PATRIOT DRIVE YORKTOWN, IN 47396

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00439462. Complaint IN00439462 - No deficiencies related to the allegations are cited. Survey dates: August 5, 6, and 7, 2024 Facility number: 014281 Residential Census: 29 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 12, 2024.	R 0000		
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance Based on observation and interview, the facility failed to provide posted and readily accessible survey results for review by the public and residents. Finding includes: During a facility tour on 8/5/24 at 10:30 a.m., the facility lacked signage regarding where to locate the survey report results. The survey results were unable to be found publicly displayed in the facility. During a facility tour on 8/6/24 at 2:00 p.m., the facility lacked signage regarding where to locate the survey report results. They were unable to be	R 0042	No resident was affected by this citied deficiency. The survey binder in each building was located in the drawer in a desk as you walked in the door. Each binder has been relocated to the top of the desk. The Executive Director and the Administrative Assistant will check for binder each day to assure it remains on top of the desk.	08/31/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Teresa Collins	Executive Director	09/06/2024

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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	found publicly displayed in the facility. During an observation and interview on 8/6/24 at 2:53 p.m., the Administrator approached the Administrative Assistant located at a desk near the entrance and asked if she had the survey report binder or knew where they were. The Administrative Assistant indicated she did not have the survey report binder and did not know where they were. The Administrator indicated the state survey report binder was not posted in a public place and lacked a sign to show residents and visitors where to find the survey results binder for review. She indicated the survey binder was to remain out and readily accessible at all times for residents and visitors. During an interview on 8/7/24 at 10:15 a.m., the Administrator indicated the facility did not have a policy regarding the posting of survey results. Residents and visitors should not have to ask to review the survey results binder. The facility followed the Indiana Department of Health guidelines regarding posted and readily accessible survey report results.		In compliance by 8/31/2024	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance Based on interview and record review, the facility failed to ensure a fire drill was completed on each shift quarterly to ensure resident safety in the event of a fire emergency. This deficiency had the potential to affect 29 of 29 residents who resided in the facility. Finding includes: During an interview on 8/5/24 at 9:53 a.m., the Administrator was requested to provide all fire	R 0092	The citied deficiency had the potential to affect all the residents. No resident was affected The maintenance tech in charge of the monthly fire drills has been counseled on proper fire drills quarterly on each shift The monthly QA meeting, the fire	09/30/2024

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	drills held from August 2023 to current during the entrance conference. A review of the fire drills conducted from 8/1/23 to 8/5/24, indicated fire drills were not completed during August 2023, September 2023, October 2023, December 2023, and March 2024. From August 2023 through October 2023, no shifts received a fire drill. From November 2023 through January 2024, only first shift and third shift received a fire drill. From February 2024 through April 2024, only first shift and third shift received fire drills. During an interview on 8/6/24 at 2:15 p.m., the Maintenance Manager indicated he was required to conduct fire drills every month, alternating to include all shifts. He had provided all of the fire drill documentation and was unable to provide any fire drills for the months of August 2023, September 2023, October 2023, December 2023, and March 2024. He did not know why the fire drills were not conducted as required. A current facility policy, undated, titled "Fire," provided by the Administrator on 8/6/24 at 2:30 p.m., indicated the following: "...Fire Drill Schedule...Fire drills will occur on a monthly basis. They will be rotated on each shift so there are 4 drills per year on each shift...."		drills for that month and the quarter will be discussed to assure compliance. Teh ExecutiveDirector will monitor on a monthly basis for compliance. 9/30/2024	
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance Based on interview and record review, the facility failed to notify the Indiana Department of Health when each secured Alzheimer's/dementia unit became operational for 2 of 2 operational Alzheimer's/dementia units reviewed. (Washington Unit and Jefferson Unit)	R 0095	This citied deficiency did not affect the residents. The paperwork has been sent to the Life and Family services and did not include the ISDH	09/30/2024

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	Finding includes: During an interview on 8/7/24 at 11:17 a.m., the Administrator in Training (AIT) indicated the Washington Unit and the Jefferson Units were both secured Alzheimer/dementia units. She was uncertain of the dates when the secured units became operational. She had not completed the "Alzheimer's/Dementia Special Care Unit" form dated 4/24/24, as it was completed by corporate staff and then emailed to her to be printed. The form lacked a signature. It indicated the DON was the Dementia Care Director. During an interview on 8/7/24 at 12:13 p.m., the Administrator indicated she was certain the secured Jefferson Unit was operational sometime prior to 12/23/23. She was unable to provide the dates when the Washington Unit and Jefferson Units became operational as locked Alzheimer/Dementia units. The facility was unable to provide any Alzheimer's/Dementia Special Care Unit forms dated prior to 4/24/24. During an interview on 8/7/24 at 12:34 p.m., the DON indicated she was the Memory Care Coordinator upon hire to the facility. Upon hire, the Jefferson Unit was already open with residents in the secured Alzheimer's/Dementia Unit. In approximately December 2023, a corporate staff member determined there was further need for another secured Alzheimer's/dementia Unit. That is when Washington Unit became a secured Alzheimer's/dementia Unit. She indicated she then assumed the responsibility of Memory Care Coordinator for both of the secured units and became the DON.		The paperwork to certify both buildings as a secured memory care and been submitted to the ISDH and is in review The Regional Director of Operations and the Executive Director follow up to assure certifications for both units has been approved by the ISDH 9/30/2024	

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	Review of the employee records indicated the DON began employment on 10/16/23. During an interview on 8/7/24 at 12:57 p.m., the Administrator indicated she had spoken with the Indiana Department of Health and they had not received any submission of certification for any locked Alzheimer's Dementia Care Units for the facility. The Indiana Department of Health should have been notified any time a secured Alzheimer's/dementia unit planned to become operational prior to housing the first resident on the secured unit. She was unable to provide a facility policy regarding the Indiana Department of Health notification of an operational secured Alzheimer's/dementia unit. The facility followed the Indiana Department of Health guidelines regarding notification of operational secured Alzheimer's/dementia units.			
R 0096 Bldg. 00	410 IAC 16.2-5-1.3(m)(1-2)(A-B)(i-iii) Administration and Management - Deficiency Based on interview and record review, the facility failed to ensure proper qualifications were maintained by the Dementia Unit Director who provided oversight for 2 of 2 secured Alzheimer's/dementia units. (Washington Unit and Jefferson Unit) This had the potential to affect 16 out of 16 residents who resided on the Washington and Jefferson Units. Finding includes: Review of the employee records, on 8/7/24 at 11:30 a.m., indicated the DON began employment on 10/16/23. The DON lacked 12 hours of dementia specific training. During an interview on 8/7/24 at 12:34 p.m., the	R 0096	Citied deficiency had the potential to affect all residents residing the dementia units. No resident was affected by this citation. The Director of Nursing services had had 7 hours of training. She will be enrolled in a dementia course to receive 5 more hours of dementia training. The Executive Director will assume the Dementia Care Director until DON has finished the 5 hours of dementia training	09/30/2024

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	DON indicated she was hired as the Dementia Care Coordinator. She remained the Dementia Care Coordinator, but she had since then accepted the DON position. A request was made for her dementia education. During an interview on 8/7/24 at 3:20 p.m., the DON indicated she had 7.5 hours of dementia care training provided. She did not have any further dementia education to provide. During an interview on 8/7/24 at 3:26 p.m., the Administrator indicated staff should have dementia training prior to providing direct care for the residents. She was unaware how much dementia training the Dementia Care Director should have had. The facility followed the Indiana Department of Health guidelines regarding dementia specific training requirements. A policy regarding dementia specific training requirements was requested and not provided prior to facility exit on 8/7/24.		The ED and the Adm Assistant will monitor her training and will be a part of her employee file . 9/30/2024	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on interview and record review, the facility failed to ensure a nursing staff member was Cardiopulmonary Resuscitation (CPR) certified for 5 of 21 shifts and first aid certified for 16 of 21 shifts reviewed for the week of staffing provided by the facility. This deficiency had the potential to affect 29 of 29 residents residing in the facility. Findings include: A review of the employee schedule for the week of 7/29/24 to 8/4/24, indicated there was not a staff member certified in CPR (cardiopulmonary resuscitation) for 5 of 21 shifts and lacked a staff	R 0117	This citied deficiency had the potential to affect all residents residing in this community No resident was affected by this citation The Director of Nursing Services has developed a system to assure all new employees and current employees have a current and valid CPR and 1st aid certification and one is scheduled every shift 24 hours a day. A class will be scheduled at the	09/30/2024

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	member certified in first aide for 16 of 21. During an interview on 8/7/24 at 3:05 p.m., the Administrator indicated the facility had no further records regarding staff CPR and first aide certifications. The facility had no written policy regarding staff certification requirements, but the facility follows the state guidelines.		community for building for each certification. When the schedule is completed, The schedule will indicate on each shift who is dually certified 7 days a week. The DON will monitor for compliance 9/30/2024	
R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency Based on record review and interview, the facility failed to ensure a Certified Nursing Assistant (CNA) did not provide care with an expired certification for 1 of 19 employees reviewed for active certifications and licensure. Findings include: A review of Employee Records on 8/8/24 at 11:04 a.m. indicated CNA 6's nursing assistant certification expired on 7/18/24. During an interview on 8/7/24 at 3:04 p.m., the Administrator indicated CNA 6 had worked the evening shift on 7/26/24 and the day shift on 7/31/24. She was not aware the CNA's certification had expired. She should not have been scheduled until the certification was valid.	R 0118	This citied deficiency did not have the potential to cause harm to the residents. The nursing assistant was a PRN employee. She has been removed from call in list until recertified. The Adm Assistant doe3s all of the onboarding for all new employees, has created a spread sheet for all new employees and current employees and will be checking on a weekly basis to assure all certifications and licenses are current. . Adm Assistant and DON will monitor for compliance.	09/30/2024

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R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on record review and interview, the facility failed to provide required education regarding the care of residents with dementia for staff working in a dementia care facility for 5 of 5 employee files reviewed. (DON, ADON, QMA 7, QMA 8, and QMA 9) Findings include: A review of the Residential Care Employee Records form was completed on 8/8/24 at 11:04 a.m. and indicated the following: a. The DON had a start date of 10/16/23. The employee's training record indicated she completed 7.5 hours of dementia training between 7/10/24 and 7/22/24. Her employee file lacked documentation of 12 hours of dementia training as the dementia care director. b. QMA 7 had a start date of 4/30/24. Her training record indicated she completed 0.5 hour of dementia training on 7/15/24. Her employee file lacked further documentation of six hours of dementia training. c. QMA 8 had a start date of 3/5/24. His employee file lacked documented dementia care training. d. The ADON had a start date of 11/14/23. Her training record indicated she completed eight hours of dementia training between 3/23/24 and 7/22/24. Her employee file lacked documentation of training completed within her first 30 days of employment. e. QMA 9 had a start date of 3/12/24. Her training	R 0120	All residents had the potential to be affected by this citied deficiency. No resident was affected. All employees are to be completed the required 6 hours of dementia training within their first 90 days of employment. The Dementia training will be monitored on a monthly basis by DON to assure the hours are being done and compliant 9/30/24	09/30/2024

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	record indicated she completed one hour of dementia training between 4/23/24 and 5/4/24. Her employee file lacked documentation of six hours of dementia training. During an interview on 8/7/24 at 3:31 p.m., the Administrator indicated employees had no additional documentation regarding dementia training and had not completed the required hours in a timely manner. A current facility policy, undated, titled, "New-Hire Process," provided by the Administrative Assistant on 8/7/24 at 10:45 a.m., included the following: "New Employee Checklist...First Two Weeks...Have employee take Relias trainings....First Month...Training and Development. Verify if needed training is completed."			
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance Based on interview and record review, the facility failed to administer TB (tuberculin) skin testing prior to starting employment with the facility for 1 of 5 staff reviewed for employee records. (DON) Findings include: Employee records were reviewed on 8/7/24 at 11:04 a.m. The DON's employee record lacked indication or documentation of completion of TB skin tests prior to working with residents. During an interview on 8/6/24 at 3:27 p.m., the DON indicated she had been employed with the facility since November of 2023. She felt she had a two step TB test when she started, but had no documentation of the testing.	R 0121	Citied deficiency had the potential to affect residents and staff. No resident or staff was affected. QA meeting was held on 8/21/2024, citation was discussed with all mangers and importance of being timely. The DON and the ADON will administer all tuberculin shots. The DON will have a file on all residents for the first and second tuberculin shots and their annual to assure compliance.	09/30/2024

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	A current facility policy, undated, titled, "Hiring Policy and Procedure," provided by the Administrator on 8/6/24 at 3:20 p.m., included the following: "...Job offers...After a decision has been made to hire all other management positions an offer will be contingent on....and required background checks and testing...."		9/30/2024	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance Based on record review and interview, the facility failed to provide job specific orientation to employees hired to work at the facility for 5 or 5 employee files reviewed. (DON, QMA 7, QMA 8, ADON, QMA 9) Findings include: A review of the Residential Care Employee Records form was completed on 8/7/24 at 11:04 a.m. The employee files for the DON, QMA 7, QMA 8, ADON, and QMA 9 lacked documentation of completion of job specific orientation. During an interview on 8/6/24 at 3:05 p.m., the Administrator indicated there was no job specific orientation or skills check off documentation completed. The employees should have completed these orientations prior to working with the facility's residents. The facility has no job specific orientation policy, but followed State guidelines.	R 0123	No resident was affected by this citied deficiency. Specific job orientation checklist were obtained and currently being completed on all current employees. The Adm Assistant will give the manger the specific job checklist at time of orientation, to be completed within the orientation period and signed. The Adm Assistant will be given the completed paperwork and it will be placed in each employee file and will monitor for compliance, After new hire orientation is completed. the file will be given to the ED to see to assure specific job check list is present and completed 9/30/2024	09/30/2024

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R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure service plans were signed by a resident and/or their representative for 6 of 7 clinical records reviewed. (Residents 8, 30, 5, 13, 19, and 12) Findings include: 1. Resident 8's clinical record was reviewed on 8/5/24 at 12:19 p.m. Diagnoses included dementia, psychotic disturbance, and liver disease. Review of the resident's current service plan, dated 6/30/24, indicated it lacked a resident or resident representative signature. The clinical record lacked any signed service plans. During an interview on 8/6/24 at 3:05 p.m., the DON indicated Resident 8's service plans were unsigned by the resident or resident representative. 2. Resident 30's clinical record was reviewed on 8/5/24 at 3:09 p.m. Diagnoses included hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side and essential hypertension. Review of the resident's current service plan, dated 6/11/24, indicated it lacked a resident or resident representative signature. The clinical record lacked any signed service plans. During an interview on 8/6/24 at 2:31 p.m., the DON indicated Resident 30's service plans were unsigned by the resident or resident representative.	R 0217	All resident 's with unsigned care plans on their chart had the potential to be affected. None were. The 12 residents citied had care plans completed, just not signed by the family and or the guardian. All have been printed and families notified ' In the future, all care plans will be printed and signed within 2 weeks The ED met with the DO and ADON and stressed the importance of service plan being done time and signed timely by the resident's family to assure family agrees with service plans and made aware if level if care has changed and if there is any increase in the monthly rent. The DN and ADON will monitor or compliance 9/30/2024	09/30/2024

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3. Resident 5's clinical record was reviewed on 8/6/24 at 10:32 a.m. Diagnoses included vascular dementia, type 2 diabetes mellitus, and chronic obstructive pulmonary disease.

Review of the resident's current service plan, dated 6/11/24,v indicated it lacked a resident or resident representative signature. The clinical record lacked any signed service plans.

During an interview on 8/6/24 at 3:05 p.m., the DON indicated Resident 5's service plans were unsigned by the resident or resident representative.

4. Resident 13's clinical record was reviewed on 8/6/24 at 10:57 a.m. Diagnoses included dementia, rheumatoid arthritis, and diastolic heart failure.

Review of the resident's current service plan, dated 7/5/24, indicated it lacked a resident or resident representative signature. The clinical record lacked any signed service plans.

During an interview on 8/6/24 at 3:05 p.m., the DON indicated Resident 13's service plans were unsigned by the resident or resident representative.

5. Resident 19's clinical record was reviewed on 8/6/24 at 1:36 p.m. Diagnoses included Alzheimer's disease with late onset and type 2 diabetes mellitus.

Review of the resident's current service plan, dated 6/30/24, indicated it lacked a resident or resident representative signature. The clinical record lacked any signed service plans.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE ASSISTED LIVING OF YORKTOWN	1400 S PATRIOT DRIVE YORKTOWN, IN 47396

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 8/6/24 at 2:31 p.m., the DON indicated Resident 19's service plans were unsigned by the resident or resident representative. 6. Resident 12's clinical record was reviewed on 8/7/24 at 11:03 a.m. Diagnoses included Alzheimer's disease, type 2 diabetes mellitus, and congestive heart failure. Review of the resident's current service plan, dated 6/30/24, indicated it lacked a resident or resident representative signature. The clinical record lacked any signed service plans. During an interview on 8/6/24 at 3:05 p.m., the DON indicated Resident 12's service plans were unsigned by the resident or resident representative. During an interview on 8/5/24 at 2:30 p.m., the DON indicated service plans were not signed because she was unaware they were required to be signed until just recently. During an interview on 8/6/24 at 3:08 p.m., the Administrator indicated the facility followed the Indiana Department of Health guidelines regarding signed service plans. Review of a current, undated facility policy, titled "Assistance/Service Plan," provided by the DON on 8/6/24 at 3:07 p.m., indicated the following: "...2. The Resident Assistant and Resident Services Coordinator will visit with the resident and family to develop the plan... 4. All components of the assistance/service plan form must be completed...."			