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	10/09/2024

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 the Investigation of Complaints IN00444035, IN00443192, and IN00441171. Complaint IN00444035 - State deficiencies related to the allegations are cited at R0052 and R0349. Complaint IN00443192 - No deficiencies related to the allegations were cited. Complaint IN00441171 - No deficiencies related to the allegations were cited. Survey dates: October 8 and 9, 2024 Facility number: 014281 Residential Census: 30 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 22, 2024.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on interview and record review, the facility failed to prevent neglect of a cognitively impaired resident who eloped from a secured memory care unit due to failure to provide supervision and ensure a secure environment to prevent the elopement of 1 of 3 cognitively impaired residents reviewed for elopement. This deficient practice resulted in the cognitively impaired resident being found alone away from facility property for one hour and forty-five minutes at night. (Resident D)	R 0052	The cited deficiency had the potential to affect all residents in the memory care units. Only one resident was affected by the citation. Residents will be supervised at all times. All service plans will be reviewed and updated to provide information	11/30/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robin Huston	Executive Director	11/01/2024

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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	Findings include: Resident D's clinical record was reviewed on 10/8/24 at 11:12 a.m. Diagnoses included, but were not limited to, vascular dementia with behavioral disturbances. Review of a service plan, dated 2/28/24, indicated Resident D had memory loss due to dementia. Review of a current care plan, dated 2/28/24, indicated Resident D would not act out in a way that was harmful to self or others. The service plan lacked indication of an elopement risk or exit seeking behaviors. During an interview, on 10/8/24 at 10:54 a.m., the Director of Nursing indicated the facility was unable to access electronic medical records from the time when the former management company ran the facility. The facility did not have clinical information for residents prior to 9/10/24. The available clinical record did not include documentation to determine the resident exhibited exit-seeking behaviors, the staff evaluated the resident's risk to elope, or the resident wandered due to records prior to September 2024. Review of a facility self-reported incident, dated 9/25/24, indicated on 9/24/23 at 9:01 p.m., Resident D exited the facility via a secured door after a vendor exited the facility. Review of an Elopement Report note, dated 9/30/24 at 4:38 p.m., indicated the QMA 5 notified the ADON that Resident D could not be found. The ADON went to the building to assist QMA 5. QMA 5 remained in the building while the ADON searched for the resident outside. Resident D was		if a resident is an elopement risk or has exit seeking behaviors. Paper documentation will be provided in a resident file containing proper information to include dx, assessment, face sheet, emergency contacts, and current service plan. Alarms are on all exterior doors. The alarm will sound when the door is left open for 15 seconds. Nursing staff will provide rounding on their shifts to be sure residents are in their assigned room and/or building. Door alarms will be checked and documented daily for proper working condition. Door alarms were placed 9/27/2024 in Jefferson building, and 10/01/2024 Washington building. Current service plans reviewed and updated for elopement risk and exit seeking behaviors by 11/30/2024 Paper documentation for resident files to be in place by 11/30/2024 as needed for current and new residents. Documentation on working door alarms will be provided by the	

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	found and returned to the building. An ambulance arrived to assess the resident. Resident D's family declined to send the resident to out to the hospital for assessment. The ADON and QMA 5 were not available during the survey for interview. Review of staffing schedules indicated QMA 5 was the only employee working in the building during the shift on 9/24/24. Security video footage from 9/24/24 was reviewed with the Maintenance Director on 10/8/24 and indicated the following: At 7:35 p.m., Resident D was observed ambulating around the front area of the building, in and out of frame, and entering another resident's room. QMA 5 sat at a table, adjacent to another resident, with her head down looking at her phone. At 7:45 p.m., QMA 5 got up from the table in response to an alarm, then returned to her previous position and activity. At approximately 8:09 p.m., Resident D continued wandering around the building and entering another resident's room. At approximately 8:12 p.m., Resident D was observed walking out of frame, towards the front door. A loud banging was heard. The Maintenance Director indicated the sound was the front door being opened and slamming closed and that this was when Resident D left the building. He indicated there was no video footage near the front door available. QMA 5 was still in the staff room. The QMA could be heard talking on her phone.		Maintenance Director and kept in Fire Drill/Elopement binder in ED's office. The Executive Director will oversee the need for revised service plans regarding when a resident is at risk for elopement.	

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	At 8:43 p.m., QMA 5 came out of the staff room, talking on her phone, and began assisting the other resident sitting at a table. QMA 5 assisted the resident to their room, then left the room at 9:06 p.m. to return to the staff room. At 9:09 p.m., QMA 5 was observed going towards Resident D's room. The QMA could be heard calling out for the resident. QMA 5 left the room and said, "Where the h--l is [Resident D]?" At 9:10 p.m., QMA 5 could be heard on her phone saying, I can't find her. The QMA continued to walk around the building and checking rooms for Resident D. At 9:14 p.m., the ADON arrived and began looking for the resident inside the building. At 9:24 p.m., the ADON and QMA 5 were still inside the building and were heard talking about not being able to find the resident. The ADON was heard on the phone calling the police to report a missing person. The ADON then left the building to look for the resident outside. During an interview on 10/9/24 at 2:16 p.m., the Emergency Services Dispatcher indicated the search was called off at 10:00 p.m., due to the resident being found. An observation of the location where Resident D was found, accompanied by the Maintenance Director on 10/8/24 at 12:30 p.m., indicated the building Resident D lived in was approximately 450 feet from the location they were found. The ground was uneven. There were grated drainage covers. The resident was found standing in front of a dense thicket. The area was poorly lit and			

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	required searchers to use flashlights. The Maintenance Director indicated Resident D was outside of the facility for over an hour and could have walked in any direction. The area the resident was found had a pond located between the building the resident lived in and where she was found. The Maintenance Director indicated the resident was found approximately 150 feet from the pond. Resident D was also found approximately 200 to 300 feet from State Road 32. The speed limit was 40 miles an hour and the area was poorly lit. During an interview on 10/9/24 at 10:36 a.m., QMA 2 indicated staff were educated on not using their personal phones while in the facility. Personal phones were only to be used while on break or due to an emergency. QMA 2 indicated Resident D had a history of wandering. QMA 2 indicated she had been trained to let visitors in and out of the building and to make sure the secured doors were closed. During an interview on 10/9/24 at 2:05 p.m., the Maintenance Director indicated he was called, and came, to the facility to assist with the search. He indicated several residents from the condo complex across the road also helped in the search. During an interview on 10/9/24 at 1:00 p.m. CNA 3 indicated Resident D was outgoing. The resident had a history of wandering and exit seeking. The resident was not safe to be outside unsupervised, her gait was steady, but she would stumble at times. The secured door required a code to be opened. CNA 3 was aware the secured doors did not always close securely. Staff were supposed to check the doors periodically to ensure they were securely locked. There was no alarm to alert			

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	staff the door was not closed securely. CNA 3 indicated during orientation they were instructed to check the doors every hour due to the residents exit seeking. Door checks were not documented. During an interview on 10/9/24 at 2:30 p.m., the DON indicated Resident D was not safe to be outside unsupervised. The facility tried to ensure the same staff were scheduled to ensure continuity, especially on the secured memory care units. A current policy dated 6/29/2018, titled "Missing Resident/Elopement Policy and Procedure" was provided by the DON on 10/9/24 at 10:11 a.m. The policy indicated the following: " .... A. Assessment: 1. Initial Elopement and Subsequent Elopement Assessment: a. All residents admitted/readmitted to the Community will be assessed by their Health Care Provider or community nurse for cognitive decline with potential for unsafe exiting from the building: .... b. Residents will be reassessed annually or more often if appropriate. c. Based on the assessment findings the Community will immediately implement appropriate interventions to prevent elopement. B. Service Plan Development 1. The Administrator or designee will develop/revise the service plan immediately upon determination that a resident is at risk for elopement. At a minimum, the service plan will be develop/revised as follows: .... b. A change in condition, which results in the resident being identified as an elopement risk. .... 4. The service plan will address the individual risk factors associated with elopement risk and will			

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	include appropriate interventions to effectively manage the identified risk factors in order to prevent an actual elopement. 5. Interventions that may be used for residents identified as high risk for elopement include but are not limited to: a. Frequent monitoring of the resident's whereabouts to assure he or she remains in the Community (e.g. 30 minute visual checks). b. Room placement /change away from exit doors. ...." This tag relates to Complaint IN00444035.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on interview and record review, the facility failed to maintain and provide staff access to accurate and up to date clinical records for the care of facility residents. This deficient practice had the potential to affect 30 residents currently residing in the facility and 4 discharged residents. (Residents C, D, E, and F) Findings include: During an interview, on 10/8/24 at 10:08 a.m., QMA 2 indicated the staff were not able to access clinical records for residents admitted prior to the previous month. Paper Medication Administration Records (MAR) were put into place, but nothing could be seen in the electronic record. The facility implemented a new electronic documentation system approximately two weeks ago and the staff were able to document electronic nursing notes. Prior to the implementation of the new electronic records system, progress notes were documented on paper and kept in a binder at each nursing station.	R 0349	This cited deficiency did not directly affect and residents. Paper documentation will be provided in a resident file containing proper information to include dx, assessment, face sheets, emergency contacts, and current service plan. All residents including current, discharged, and future residents will have a file on site. A resident file will be put in place the day of move-in with proper documentation. The Executive Director will monitor the compliance for the resident charts. Resident paper files will be	11/30/2024

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	Review of the binder indicated paper notes for two current residents, dating from 9/12/24 through 9/20/24. During an interview, on 10/8/24 at 10:54 a.m., the Director of Nursing indicated the facility was unable to access electronic medical records from the time when the former management company ran the facility. The former management company refused to give the current management company (and facility) access to the resident's medical records. The management company transition occurred between 9/10/24 and 9/12/24. The facility did not have clinical information for residents prior to 9/10/24. Paper medication administration records were provided by the pharmacy. The DON indicated if a resident discharged on or prior to 9/10/24, the facility did not have access to the medical records. The DON did not know why the paper progress notes located in the binder had documentation only from 9/12/24 through 9/20/24. The DON did not know why the prior management company had refused to provide the clinical record, but indicated lawyers were involved. On 10/9/24 at 10/9/24 at 1:45 p.m., a Corporate Consultant provided face sheets, which contained emergency contacts, insurance, and diagnoses information, for Residents C, D, E, and F. The Consultant indicated this was the only information they were able to get from the discharged clinical records. This citation relates to Complaint IN00444035.		completed by 11/30/2024.	