| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 04/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HERITAGE ASSISTED LIVING OF YORKTOWN | 1400 S PATRIOT DRIVE<br>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 |
|---|---|---|---|---|
| R 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00430311 .<br><br>Complaint IN00430311 - State deficiencies related to the allegations are cited at R0064 and R0090.<br><br>Survey date: April 1 and 2, 2024<br><br>Facility number: 014281<br><br>Residential Census: 23<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed April 4, 2024. | R 0000 | =”” p=””><br><br>This Plan of Correction is not to be construed as an admission of, or agreement with the findings and conclusions in the statement of deficiencies. This plan of correction is being submitted as required by the regulation. | |
| R 0064<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(hh)<br>Residents' Rights- Noncompliance<br>(hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident.<br>Based on record review and interview, the facility failed to prevent the misappropriation of resident property, as evidenced by missing narcotic medications of a resident (Resident B) for 1 of 3 residents reviewed for misappropriation of property.<br><br>Findings include:<br><br>The clinical record for Resident B was reviewed on 4/1/24 at 2:16 p.m. Diagnoses included urinary | R 0064 | /p><br><br>R0064<br>1 The resident affected by this cited deficiency; steps will be put into place to ensure no misappropriation of resident property will occur again.<br>2 All residents with orders for narcotics have potential to be affected by cited deficiency | 04/20/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Nicole Fenton | AIT | 04/19/2024 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 04/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HERITAGE ASSISTED LIVING OF YORKTOWN | 1400 S PATRIOT DRIVE<br>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 |
|---|---|---|---|---|
| | tract infection, hypertension, chronic pain, and Adult Failure to Thrive Syndrome.<br><br>Review of Resident's orders, on 4/1/24 at 2:16 p.m., indicated they had an 11/28/23 order for oxycodone-acetaminophen (analgesic) 10-325 mg one tablet every 4 hours as needed for pain.<br><br>A facility self-reportable, dated 3/11/24, indicated on 3/8/24 a locked box with several bottles of oxycodone-acetaminophen for Resident B, had been missing during a narcotic count. The facility initiated an investigation and had all nursing staff that had worked that medication cart from 3/7/24 through 3/8/24 screened for drug use.<br><br>During an interview on 4/1/24 at 12:15 p.m., the AIT (Administrator in Training) indicated per the facility investigation, corporate instructed the facility to not allow QMA 1 to pass medications or have access to the medication room.<br><br>During an interview on 4/1/24 at 3:07 p.m., the DON indicated when Resident B admitted to the facility, she had several loose bottles of medication (5-6 of bottles of narcotics). Around December 2023, the previous DON instructed staff to keep the bottles in the medication cart. The current DON and the Regional Clinical Director had counted all the medications (bottles) when she began her employment and made sure the count sheets were correct.<br><br>During an interview on 4/2/24 at 9:29 a.m., the DON indicated when Resident B admitted to the facility on 9/1/23, the family brought in several bottles of narcotic medication. The medication was counted by the previous DON, and placed back into the bottles. The bottles were then placed in a lock box. The locked box was placed | | practice.<br>3 Inservice held 3/12/24 on administering narcotics, narcotic count with each shift change, medication destruction and documentation.<br>All new residents upon admission will be informed if they use an outside pharmacy that only one bottle of a medication will be allowed at a time.<br>4 DON will monitor narcotic count weekly to ensure compliance. ED and DON will ensure compliance.<br>5 4/20/24 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 04/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HERITAGE ASSISTED LIVING OF YORKTOWN | 1400 S PATRIOT DRIVE<br>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 |
|---|---|---|---|---|
| | in the secured medication cart. The DON was the only person with a key to the locked box. The narcotic count book had a sheet dedicated to the box, titled "1 box". On 3/8/24, the DON had taken over the medication cart in the middle of a shift and noticed the box was missing. The DON called LPN 2 and asked about the missing medications and was told that QMA 1 had told LPN 2 she (the DON) had destroyed the medication. The DON indicated she had not destroyed the medication.<br><br>During an interview on 4/1/24 at 1:07 p.m., LPN 2 indicated on 3/7/24 she and QMA 1 were counting narcotics. LPN 2 had worked that cart often, and was very familiar with the mediations. She noticed the locked box was missing and asked QMA 1 what had happened to Resident B's narcotics. QMA 1 indicated the DON and ADON had destroyed the medications. LPN 2 thought it was strange, but did not question it and did not call the DON to confirm the information. LPN 2 wished she had called the DON.<br><br>During an interview on 4/1/24 at 10:19 p.m., QMA 1 indicated she had not worked that particular medication cart frequently. QMA 1 worked the night shift (10:00 p.m. to 6:00 a.m.) on 3/7/24, and the medication box was not present. She assumed it had been destroyed by the DON and the ADON.<br><br>During an interview on 4/2/24 at 10:02 a.m., LPN 4 indicated she worked the evening shift (2:00 p.m. to 10:00 p.m.). She counted the narcotics on Wednesday, 3/6/24 and Resident B's narcotic box was present. She worked Thursday, 3/7/24 and the narcotic box was present. LPN 4 indicated the DON was the only one with the key to Resident B's narcotic box. She did not know what the box was and thought it was an emergency medication | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 04/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HERITAGE ASSISTED LIVING OF YORKTOWN | 1400 S PATRIOT DRIVE<br>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 |
|---|---|---|---|---|
| | kit. If the narcotic count was not correct, staff should call the DON.<br><br>During an interview on 4/2/24 at 10:11 a.m., LPN 2 indicated she worked the day shift (6:00 a.m. to 2:00 p.m.) and did the narcotic count with QMA 1 on Friday, 3/8/24. Resident B's narcotic box was missing; she asked QMA 1 what happened to the box. QMA 1 told her the medications had been destroyed by the DON and ADON. At the end of her shift, she counted with the evening shift LPN. The evening shift LPN had been moved to another area during the evening shift and was replaced by the DON. The DON called LPN 2 at home and asked what happened Resident B's narcotic box. The DON indicated they had not destroyed Resident B's narcotics.<br><br>A current policy, dated 11/25/23, titled "Narcotic/Controlled Substance Monitoring was provided by the DON on 4/2/24 at 10:30 a.m. The policy indicated the following:<br>" .... Procedures: ....<br>ANY discrepancies noted with the narcotic count will immediately be reported to the Director of Nursing and the Executive Director. The management team will be responsible for informing the Regional Director of Clinical Services, as well as the Regional Director of Operations. ...."<br><br>This State tag relates to complaint IN00430311. | | | |
| R 0090<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(g)(1-6)<br>Administration and Management - Deficiency<br>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:<br>(1) Informing the division within twenty-four | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 04/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HERITAGE ASSISTED LIVING OF YORKTOWN | 1400 S PATRIOT DRIVE<br>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 |
|---|---|---|---|---|
| | (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:<br>(A) epidemic outbreaks;<br>(B)poisonings;<br>(C) fires; or<br>(D) major accidents.<br>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.<br>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.<br>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.<br>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:<br>(A) employee's full name; and<br>(B) dates and hours worked during the past twelve (12) months.<br>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.<br>(6) Maintaining reports of surveys conducted by the division in each facility for a period of | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 04/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HERITAGE ASSISTED LIVING OF YORKTOWN | 1400 S PATRIOT DRIVE<br>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 |
|---|---|---|---|---|
| | two (2) years and making the reports available for inspection to any member of the public upon request<br>Based on interview and record review, the facility failed to ensure staff reported an allegation of medication diversion to the appropriate state agencies per facility policy in a timely manner.<br><br>Findings include:<br><br>The clinical record for Resident B was reviewed on 4/1/24 at 2:16 p.m. Diagnoses included urinary tract infection, hypertension, chronic pain, and Adult Failure to Thrive Syndrome.<br><br>Review of current physician orders indicated an 11/28/23 order for oxycodone-acetaminophen (analgesic) 10-325 mg one tablet every 4 hours as needed for pain.<br><br>A facility reportable, dated 3/11/24, indicated on 3/8/24 a locked box with several bottles of oxycodone for Resident B, had been missing during a narcotic count. The facility initiated an investigation and had all nursing staff that had worked that medication cart from 3/7/24 through 3/8/24 screened for drug use.<br><br>During an interview on 4/1/24 at 2:37 p.m., the DON indicated she had become aware of the missing medications on 3/8/24 and initiated an investigation. She did not report the incident to the appropriate state agencies because she had been overwhelmed and did not submit a report until 3/11/24.<br><br>A current undated policy, titled "Incident Reporting" was provided by the AIT (Administrator in Training) on at 4/1/24 at 4:21 p.m. The policy indicated the following: | R 0090 | =”” p=””><br>R 0090<br>1No residents affected by this cited deficiency.<br>2 No residents affected by this cited deficiency.<br>3 State reportable will be submitted in 24 hour time frame.<br>4 Regional Nurse and RDO will be notified at time of incident for follow up of compliance and allow timely reporting.<br>5 4/20/24 | 04/20/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 04/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HERITAGE ASSISTED LIVING OF YORKTOWN | 1400 S PATRIOT DRIVE<br>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 |
|---|---|---|---|---|
| | ".... Procedures ....<br>If the incident involves a resident, within state regulatory guidelines for reporting, the Executive Director/designee will complete required reporting of resident incidents to any state regulatory authorities, as required by law...<br>If abuse is suspected: Facility Nurse, designee, and/or Executive Director will notify state regulatory authorities within regulatory guidelines of occurrences involving but not limited to suspected or confirmed mistreatment, neglect, or abuse, including injuries of unknown origin...."<br><br>A current policy, dated 11/25/23, titled "Narcotic/Controlled Substance Monitoring was provided by the DON on 4/2/24 at 10:30 a.m. The policy indicated the following:<br>" .... Procedures: ....<br>ANY discrepancies noted with the narcotic count will immediately be reported to the Director of Nursing and the Executive Director. The management team will be responsible for informing the Regional Director of Clinical Services, as well as the Regional Director of Operations. ...."<br><br>A current undated policy, titled "Elder Abuse Policy and Procedures" was provided by the AIT on 4/1/24 at 4:21 p.m. The policy indicated the following:<br>" .... Definitions: ....<br>Misappropriation of resident property - the deliberate misplacement, exploitation or wrongful,, temporary or permanent use of a resident's belongings or money without the resident's consent. ....<br>Reporting/response:<br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin and | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 04/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HERITAGE ASSISTED LIVING OF YORKTOWN | 1400 S PATRIOT DRIVE<br>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 |
|---|---|---|---|---|
| | misappropriate of resident's property are reported immediately to the Administrator or his designated representative of the facility and to other officials in accordance with the State law through established procedures (including to the State survey and certifications agency) Within [sic] 24 hours with the immediate report and within 5 days with the final report The facility shall report alleged violations and all substantiated incidents to the state agency and to all other agencies as required and take all necessary corrective actions depending on the results of the investigation. ...."<br><br>This State tag relates to complaint IN00430311. | | | |