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	10/10/2023

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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00419023. Complaint IN00419023 - State deficiencies related to the allegations are cited at R0052 and R0118. Survey date: October 10, 2023 Facility number: 014281 Residential Census: 7 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 13, 2023.	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 record review and interview, the facility failed to report witnessed aggressive physical contact between to two residents (Resident B and Resident C), to the Administrator per facility policy. This deficient practice resulted in a delay in the investigation to protect Resident B and reporting to the appropriate State agency. Findings include: The clinical record for Resident B was reviewed	R 0052	All concerns of behaviors will be reported to the ED and DON immediately. Family and physician will be notified. p> The service plan will be updated for the intervention and plan for decrease of the behavior.	11/17/2023

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

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	on 10/10/23 at 9:48 a.m. Diagnoses included history of blood clots. Review of the initial service plan, dated 10/5/23, indicated the resident required total assistance for bathing and personal hygiene, dressing and grooming and toileting. The clinical record for Resident C was reviewed on 10/10/203 at 9:53 a.m. Diagnoses included dementia, hyperlipidemia, hypertension and anemia. Confidential interviews were completed during the survey. During an interview Employee 3 indicated, while on the dementia unit on 10/5/23, they heard yelling. Upon entering the room of Resident B and Resident C, Employee 3 witnessed Resident C forcefully shaking Resident B while she sat in her recliner. Employee 3 went to report the incident to the Administrator, but the Administrator was in a meeting. They did not interrupt the meeting to report the incident. Employee 3 did not know if anyone reported the incident. During an interview Employee 2 indicated, on 10/5/2023, they witnessed Resident C grabbing and squeezing the arms of Resident B and shaking her. Resident B was screaming for Resident C to stop and that it was hurting her. Employee 2 reported this to the immediate supervisor, but did not know if the Administrator was aware of the incident. During an interview on 10/10/23 at 3:00 p.m., the Administrator indicated she had not been made aware of the incident. The incident had not been investigated, nor reported to the State Agency.		All staff will have in-service on dementia and behaviors regarding what constitutes abuse between residents and involving staff. Training on what to look for, how to react, and how to handle the situation at hand.	

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	Review of a current, undated facility policy, titled "Elder Abuse Policy and Procedure", indicated ".... The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin and misappropriate of resident 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}...."			
R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on record review and interview, the facility failed to provide adequate qualified staffing for 2 of 2 residents living on a dementia unit. This deficient practice resulted in non-nursing staff providing resident ADL (activities of daily living) care and mobility transfers. Findings include: The clinical record for Resident B was reviewed on 10/10/23 at 9:48 a.m. Diagnoses included history of blood clots. The resident was admitted on 10/5/2023. Review of the initial service plan, dated 10/5/23,	R 0118	/p> The schedule will be audited by ED, DON, and MC Director to assure staffing is adequate and meets the definition of qualified staff. The monitoring of the schedule will continue for 60 days for consistency in qualified staffing.	11/17/2023

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	indicated the resident required total assistance for bathing and personal hygiene, dressing and grooming and toileting. The clinical record for Resident C was reviewed on 10/10/203 at 9:53 a.m. Diagnoses included dementia, hyperlipidemia, hypertension and anemia. Review of the nursing work schedule for 10/5/23 indicated, due to a call in, there was no nursing staff from 6:00 a.m. to 11:00 a.m. Confidential interviews were conducted during the survey. During an interview Employee 1 indicated, on 10/5/23, there was no nursing staff on the dementia unit. Employee 1, who was neither a nurse, nor an aide, assisted another non-nursing staff member with toileting Resident B. Employee 1 indicated they had no training in resident care. During an interview Employee 2 indicated, on 10/5/23, there was no nursing staff on the dementia unit. They had been told to go to the dementia unit and sit with the residents until nursing staff arrived. Employee 3 (non-nursing staff) was also on the unit. Resident C (husband of Resident B) had placed Resident B on the toilet. Resident B was screaming because she was unable to get off the toilet on her own. Employee 3 and Employee 1 lifted the resident from the toilet. Employee 2 indicated none of the staff members present had been trained in resident care. During an interview Employee 3 indicated, on 10/5/23, the facility had no nursing staff. The Employee had been told Employee 2 had been		Education with in-service including tabletop will be presented to all staff regarding the scope of practice that unqualified staff can and cannot provide for all residents.	

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	instructed to "keep an eye on the residents in memory care". Employee 3 was performing cleaning duties on the memory care unit. The Employee was advised that Resident B was unable to get up from the toilet and was being very vocal about the situation. Employee 3 asked for assistance from Employee 1 and together they cleaned the resident and lifted her into her wheelchair. After breakfast, Resident B was having difficulty putting in her hearing aides. Employee 3 and Employee 2 attempted to assist the resident, but could not get the hearing aides in. Employee 3 sent a text about the hearing aides to the Activity Director at 9:16 a.m. The Activity Director was also a Home Health Aide. Employee 3 indicated they did not receive a response from the text until 12:15 p.m. During an interview on 10/10/23 at 3:00 p.m., the Administrator indicated the facility had staffing issues on 10/5/2023, due to the day shift nursing staff calling off. The facility had no nursing staff. The Administrator indicated it was "all hands on deck" until they could get nursing staff into the facility. The Administrator indicated she had never been notified that non-nursing staff had provided care to the residents. The facility was without nursing staff from 6:00 a.m. until 10:00 a.m.			