STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/19/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Intakes 470112 and 469756. Intake 470112 - State deficiencies related to the allegations are cited at R052, R060, R092, and R117 Intake 469756- No deficiencies related to the allegations are cited. Survey dates: June 17, 18 , and 19, 2026 Facility number: 14281 Residential Census: 38 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 24, 2026	R 0000		

R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation, interview, and record review, the facility failed to ensure the most recent state survey results were readily accessible to residents and visitors. Findings include: During a facility entrance tour, on 6/17/26 at 9:30 a.m., no survey binder was visible in the Lincoln building. During a facility observation, on 6/17/26 at 11:51 a.m. a survey binder was observed in the Washington building. The most recent survey present in the binder was dated 7/16/25-7/17/25. The survey binder lacked the most recent survey results dated 12/22/25. During an interview, concurrent to the above observation, QMA 9 indicated the binder was up to date with the most recent survey results.	R 0042	The deficiency was corrected on **June 19, 2026**. A survey binder containing the most recent Indiana Department of Health survey report was placed in each of the facility's three buildings in a readily accessible location. A sign was posted at each location identifying the survey binder for residents, families, visitors, and the public. This did not directly impact resident care. A facility policy has been implemented to ensure up-to-date survey results, regular review of the survey binder, and accessibility of the binder. The Executive Director shall complete monthly reviews of the binder to ensure it is up-to-date. IDR has been requested for this tag due to this being an isolated incident during an interim Executive Director position.	

	During an observation, on 6/17/26 at 12:33 p.m., the survey binder was just inside the main entrance of Jefferson building on the table to the left of the door. The most recent survey results posted in the binder were dated 7/17/25. Prior survey results in the survey binder were dated 8/7/24, 7/18/24, 6/14/24, 4/2/24, 2/1/24, and 8/30/23. The binder lacked results dated 12/22/25. During an interview, on 6/17/26 at 12:46 p.m., CNA 14 indicated the survey binder in the Jefferson building lacked any survey results since the last annual licensure on 7/17/25. The above listed survey dates were the only survey reports in the binder available to residents, staff, and visitors. During an interview, on 6/17/26 at 1:31 p.m., the Activity Director indicated the survey binder for Lincoln should have been on the entrance desk. She would need to message administration to see where the binder was located. During an interview, on 6/17/26 at 1:48 p.m., the Activity Director indicated the survey binder was in the BOM's office. During an interview, on 6/19/26 at 2:41 p.m., the Corporate Nurse Consultant indicated the most recent survey results			

	should have been up to date and readily available in each building for residents and visitors to review. A current facility policy titled, "Resident Rights Policy", revised 6/2026, and provided by the Corporate Nurse Consultant on 6/19/26 at 3:23 p.m., indicated the following: " ...Procedure: Each resident of a licensed residential care facility has the right to: 20. Examine, upon reasonable request, the results of the most recent survey of the facility conducted by the state and any plan of correction in effect with respect to the facility ...."			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (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. 2. Resident F's record was reviewed on 6/19/26 at 1:48 p.m. Medical diagnoses	R 0052	The deficient practice was corrected directly after identification. Door codes were reviewed and provided to all residents that did not have a door code for access after normal business hours in building 1 and building 3. Building 2 will not require resident door codes due to Memory Care. An audit was performed to ensure that all residents had a door code, any identified resident without a door code was immediately given a door code. A policy has been created to ensure proper assignment of door codes prior to move-in. The Executive Director or designee will conduct weekly audits for four weeks, followed by monthly audits for two	

	included chronic cluster headache, mood disorder, and abdominal distention. A 4/13/26 Initial Service Plan indicated the resident was cognitively intact and was able to evacuate independently. During a telephone interview, on 6/19/26 at 2:13 p.m., the Regional Director of Operations indicated residents in Jefferson building should have access to come and go as they wished. She believed all residents in the Jefferson building had a code to get in and out after hours when the doors were locked. A current facility policy title, "Resident Rights Policy", revised 6/2026, and provided by the Corporate Nurse Consultant on 6/19/26 at 3:23 p.m. indicated the following: " ...8. Be free from: Restraints Abuse Neglect Exploitation Corporal punishment Involuntary seclusion ...." This citation relates to Intake 470112. Based on observation, interview, and record review, the facility failed to ensure residents were free from involuntarily seclusion for 2 of 6 residents reviewed for environment. (Resident B and Resident F)		additional months, to verify: • All eligible residents have assigned and functioning access codes. • Newly admitted or transferred residents receive access codes before occupancy. • The access code roster remains accurate and current. • Any identified concerns are corrected immediately.	

	Findings include: During an observation, on 6/18/26 at 1:34 a.m., an entry to the Jefferson building was attempted and the building doors were locked. A code was required to gain entry to the building. No staff were present. On 6/18/26 at 1:41 a.m., an exit from the Jefferson building was attempted but the doors were locked. A code was required to exit the building. No staff were present. During an interview, on 6/18/26 at 1:45 a.m., QMA 7 indicated the doors to Jefferson building locked at 8:00 p.m. each evening and remained locked until morning. A code was required for anyone to enter or exit Jefferson building during the night. Each resident in the Jefferson building had a code that allowed them to enter and exit the building when the doors were locked. A staff member was not scheduled to remain in the Jefferson building at night. On 6/18/26 at 10:27 a.m., Resident B indicated she was aware the entrances/exits locked from 8:00 p.m. to 8:00 a.m. She did not have a code to allow her to enter and exit the building during the times the doors were locked. 1. Resident B's clinical record			

	was reviewed on 6/18/26 at 4:58 a.m. Diagnosis included Parkinsonism, transischemic attack (TIA), and rheumatoid arthritis. A 3/27/26, service plan indicated staff would assist the resident for evacuation assistance in case of an emergency. During an interview, on 6/19/26 at 11:56 a.m., the Maintenance Director indicated he did not have pass codes set up for Resident B and Resident F to get in and out of the Jefferson building from 8:00 p.m. to 8:00 a.m. when the doors were locked. He did not realize there were residents without codes in the Jefferson building until pass codes were reviewed on 6/19/26 at 11:56 a.m. On 6/19/26 at 12:06 p.m., the Maintenance Director indicated codes were not posted anywhere on campus for any of the buildings to enable anyone to enter/exit the buildings after hours when the doors were locked.			
R 0060	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(dd) (dd) The facility shall provide reasonable access to any resident, consistent with facility policy, by	R 0060	The deficient practice was corrected upon identification. On 7/6/2026, the facility RDO re-distributed the code to EMS, Fire, and Police by email. The maintenance director verbally communicated the code to the	

	any entity or individual that provides health, social, legal, and other services to any resident, subject to the resident ' s right to deny or withdraw consent at any time. Based on observation and interview the facility failed to ensure residents had timely access to emergency medical services (EMS) for 1 of 6 residents reviewed for environment. (Resident B) Finding includes: During an interview,on 6/18/26 at 1:22 a.m., CNA 6 indicated the staff in Washington building (memory care secured building) were not allowed to leave the Washington building at night without another staff member replacement. Staff were required to let the Emergency Medical Services (EMS) into the building on night shift when they came because EMS did not have a code to get in. No staff were scheduled/stationed in Jefferson building during night shift. The doors were locked and would not open without a code. During an observation, on 6/18/26 from 1:34 a.m. to 1:41 a.m., an entry to the Jefferson building was attempted and the building doors were locked. After the code was entered, provided on 6/17/26, the		appropriate dispatch center. This ensures the immediate availability for emergency response use. All residents within the community were identified as potentially affected by this practice. The Executive Director or designee shall test the emergency code quarterly and report any issues with door code systems immediately.	

	building was entered and searched with no staff present in the building. During an interview, on 6/18/26 at 1:45 a.m., QMA 7 indicated she was stationed/remained in the Lincoln building on night shift unless she went to Jefferson building or Washington building to answer a call light. The call lights rang to the phones and iPAD in each building campus wide. No staff were scheduled to remain in the Jefferson building on night shift. A staff member had to let EMS into the buildings when they came to the buildings at night because EMS did not have a code to get into the buildings. During an observation, on 6/18/26 at 2:33 a.m., the Jefferson door was locked and required a code to enter. A code was not posted anywhere. A code unlocked the door and no staff were present for supervision. On 6/18/25 at 2:45 a.m., QMA 8 indicated a couple of weeks ago at 12:55 a.m. she was contacted by the staff member who was on duty at the Washington building. The staff member scheduled in the Washington building asked QMA 8 why the EMS was outside at the Jefferson building. She was unaware how			

	long EMS had been waiting to get into Jefferson building because she did not call EMS and she was in Lincoln building. EMS did not have codes to get in and out of the buildings at night when the doors were locked. QMA 8 believed the EMS had been dispatched due to Resident B's watch sending a notification that the resident had a fall. QMA 8 entered her code to allow the EMS into the building to assist Resident B. QMA 8 was concerned for the safety of the ten residents in Jefferson building at night because no staff remained in the building at night to assist with emergencies. Resident B's clinical record was reviewed on 6/18/26 at 4:58 a.m. Diagnosis included Parkinsonism, transischemic attack (TIA), and rheumatoid arthritis. The resident's clinical record lacked any indication the resident had EMS services dispatched to the building from her watch fall alert device. During an interview, on 6/19/26 at 12:06 p.m., the Maintenance Director indicated codes were not posted anywhere on the campus for any of the buildings to enable anyone to enter/exit the buildings after hours when the doors were locked. During a telephone interview, on			

	6/19/26 at 2:13 p.m., the Regional Director of Operations indicated residents had the right to receive timely services from outside providers such as EMS. A current facility policy, revised 6/2026, titled " Resident Rights Policy," provided by the Corporate Nurse Consultant on 6/19/26 at 3:23 p.m., indicated the following: " Purpose: The purpose of the Resident Rights Policies is to ensure that all residents of the facility are treated with dignity, respect, and consideration, and that their fundamental rights are fully protected in accordance with Indiana State regulations...." This citation relates to Intake 470112.			
R 0088	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) c) The licensee shall: (1) appoint an administrator with either a: (A) comprehensive care facility administrator license as required by IC 25-19-1-5(c); or (B) residential care facility administrator license as required by IC 25-19-1-5(d); and (2) delegate to that administrator	R 0088	No residents were identified as being adversely impacted by this deficient practice. The facility recognizes that consistency in the Executive Director presence is essential to the daily operations, regulatory compliance, and resident services. A new Interim Executive Director has been appointed as of 7/13/2026 to be present Monday, Wednesday, and Friday meeting the requirement of 60% or more as stated by the residential regulations. A permanent Executive Director has been secured to start within 30 business days to provide full-time onsite coverage five days per week. The RDO will conduct	

	the authority to organize and implement the day-to-day operations of the facility. (d) The licensee shall notify the director: (1) within three (3) working days of a vacancy in the administrator's position; and (2) of the name and license number of the replacement administrator Based on observation, interview, and record review, the facility failed to ensure an administrator was present for day to day operations.This had the potential to impact 38 of 38 residents who resided at the facility. Finding includes. During an interview, on 6/17/26 at 9:40 a.m., the DON indicated the administrator was working remotely and was unable to attend entrance conference. During a random facility observation, on 6/18/26 from 6:00 a.m. to 11:15 a.m., the administrator was not present in any of the facility buildings. During an interview, on 6/19/26 at 9:01 a.m., the BOM indicated the administrator would be in a little later in the day. The Administrator was typically at the facility 1 to 2 days a week,		weekly check-ins with the interim director and onsite leadership teams to ensure compliance, interim ED onsite presences, and oversight of day to day operations as applicable.	

	usually Tuesday and Thursday. When the administrator was not in the building, the BOM typically handled things on a day to day basis. During a 6/19/26 interview at 9:40 a.m., the Corporate Nurse Consultant indicated the Administrator would not be in the building that day as she had previously planned the day off. During a 6/19/26 interview at 12:24 p.m., the DON indicated he typically saw the Administrator on Mondays and Thursdays, but the Administrator did not have set schedule. The Administrator was last on site 6/17/26. During a random facility observation, on 6/19/26 between 9:08 a.m. and 1:50 p.m., the administrator was not present in any of the facility buildings. During a telephone interview, on 6/19/26 at 1:51 p.m., the Administrator indicated she did not have a set schedule for when she worked on site at the facility. She attempted to come to the facility 2 to 3 times a week and at different hours of the day, depending on what needed to be done. When she worked remote, the Administrator checked the residential charting software and her email regarding any recent			

	incidents. The DON and BOM kept her up to date on the day to day events at the facility. The Regional Director handled the budget for the facility while the Administrator handled the day to day facility operations. During a telephone interview, on 6/19/26 at 2:13 p.m., the Regional Director indicated the Administrator was to be on site at the facility 60% of the time. The Administrator is available via telephone 24 hours a day, but was not at the facility 5 days a week. A current facility document titled, "Job Description Executive Director " , revised 2/2026, and provided by the BOM 6/19/26 at 1:19 p.m., indicated the following: " ...The Executive Director for Vita Assisted Living/Memory Care is responsible for overseeing the daily operations, financial performance, staff management, and regulatory compliance of the community ...Essential Job Functions include the following: Regulatory Compliance & Licensure- Maintain full compliance with Indiana Department of (IDOH) regulations for Residential Care Facilities (410 IAC 16.2) Serve as the designated contact for licensure requirements Ensure that facility policies and procedures are followed in			

	accordance with Indiana State Department of Health regulations ...Ensures the comprehensive needs of residents are met, including but not limited to: Conducting routine rounds throughout the facility to personally verify that residents receive optimal care, the environment is maintained in a safe and sanity manner, appropriate systems are in place, and staff are properly attired and adequately supervised .... "			
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded	R 0092	No residents were identified as having been harmed as a result of this deficient practice. The facility immediately reviewed and revised the Emergency Preparedness Plan to ensure coordination and distribution appropriately and accordingly. The updated Emergency Preparedness Plan was distributed via email to the appropriate local and county authorities. All residents in the facility had the potential to be impacted by this deficiency. The Maintenance Director will continue to complete monthly fire drills and facility inspections to ensure resident safety at all times. The Executive Director will review the Emergency Preparedness Binder on a monthly basis to ensure accuracy of the details and update accordingly. Staff shall receive in-service on the facility emergency procedures.	

	announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on observation, interview, and record review, the facility failed to ensure an emergency disaster plan and fire drills were coordinated with the local fire department for 2 of 6 residents reviewed for environment. (Resident B and Resident G) Findings include: During an interview,on 6/18/26 at 1:22 a.m., CNA 6 indicated the staff in Washington building (memory care secured building) were not allowed to leave the Washington building at night without another staff member replacement. No staff were scheduled/stationed in Jefferson building during night shift. The doors were locked and would not open without a code. During an observation, on 6/18/26 from 1:34 a.m. to 1:41 a.m., an entry to the Jefferson building was attempted and the doors were locked. After the code was entered on the			

	keypad, the building was entered and searched with no staff present in the building. During an interview, on 6/18/26 at 1:45 a.m., QMA 7 indicated a total of two staff members were present on the current shift. Two staff members were normally scheduled for night shift. She was stationed/remained in the Lincoln building on night shift unless she left to answer a call light or pass medications in Jefferson building or Washington building. CNA 6 was assigned to the Washington building and remained in Washington building for the night shift. No staff were scheduled to remain in the Jefferson building on night shift. She was glad they did not get the projected tornado activity on her shift tonight. If all three buildings were hit with a tornado and residents were injured in all three buildings she would not be able to leave injured residents without a staff member in one building to go to the other building that lacked a staff member. She would try to call the DON to seek additional assistance. During an observation, on 6/18/26 at 2:33 a.m., QMA 7 and QMA 8 entered Jefferson building during shift change and the lights were dim. No staff members were present in the			

	building when the building was entered. On 6/18/25 at 2:45 a.m., QMA 8 indicated she was concerned for the safety of the ten residents who resided in Jefferson building because no staff remained in the building at night to assist with emergencies. She felt the residents could physically get themselves out of the building in the event of a fire, if they had enough time. QMA 8 did not know what would happen if all three buildings were hit with a tornado at night because they only had two staff members on duty and there were three buildings with residents in them. Quarterly fire drills were reviewed on 6/18/26 at 2:55 a.m. The documents lacked fire drills in coordination with a local fire department or other emergency entity.. 1. Resident B's clinical record was reviewed on 6/18/26 at 4:58 a.m. Diagnosis included Parkinsonism, transischemic attack (TIA), and rheumatoid arthritis. The resident resided in Jefferson building. A 3/27/26, service plan indicated staff would assist the resident for evacuation assistance in case of an emergency.			

	During an observation, on 6/18/26 from 5:00 a.m. to 5:49 a.m., QMA 8 went to Washington building and Jefferson building to pass medications. The Lincoln building did not have a staff member present in the building to provide assistance such as first aide or CPR while she was gone to the other buildings. 2. Resident G's clinical record was reviewed on 6/18/26 at 8:19 a.m.. Diagnosis included rhabdomyolysis, dementia, and osteoarthritis. The resident resided in Lincoln building. A 6/1/26, service plan indicated staff would assist the resident for evacuation in the event of an evacuation. During an interview, on 6/18/26 at 10:59 a.m., the Maintenance Director indicated fire drills were not performed in conjunction with local fire departments. The departments had been reached out to, but had not responded. A policy regarding fire drills was requested during the interview.			

	Review of an undated emergency preparedness document, provided by the facility, lacked coordination with emergency management agencies and coordination with local emergency responders. Multiple pages of the document were left incomplete. On 6/19/26 at 12:06 p.m., the Maintenance Director indicated he has been a staff member at the facility since they brought in the first resident when the facility first opened. He never set up a disaster preparedness plan or fire drills in conjunction with the fire department. He was unable to provide correspondence to show any attempts to set up fire drills or a disaster preparedness plan with the local fire department. Codes were not posted anywhere on campus for any of the buildings to enable anyone to enter/exit the buildings after hours when the doors were locked. During an observation, on 6/19/26 from 12:10 p.m. to 12:14 p.m., the Maintenance Director measured the path taken on foot during night shift observations. The distance was 886 feet and 1 inch from the North front entrance of Jefferson building to the front main entrance of Lincoln building. During a telephone interview, on			

	6/19/26 at 2:13 p.m., the Regional Director of Operations indicated the facility had three buildings but was considered as one building. They had never been asked how residents in all three buildings would receive necessary assistance in a disaster event where all three buildings had injured residents and only two staff members were on campus. The plan needed revisited. The facility had a change in management and the emergency preparedness binder remained incomplete with many blanks. The facility was advised not to use the binder until it was completed and distributed to the local fire department. Further information was not provided prior to exit on 6/19/26 at 3:30 p.m. A current facility document, undated, titled "Introduction to The Emergency Management Plan, " provided by the Corporate Nurse Consultant on 6/19/26 at 1:19 p.m., indicated the following: "a. Mission...The facility shall facilitate appropriate communication with all emergency management agency in its respective county... as well as other local, regional, and state agencies. b. Purpose... The purpose of this policy is to provide all hazard approach... in the event of any			

	emergency, crisis, or disaster that may impact the safety of its residents. The desired outcome of the facility is to provide protection and preservation of residents, employees, and families...." This citation relates to Intake 470112.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be	R 0117	No resident suffered negative outcome as a result of the cited practice. Residents residing in Lincoln and Jefferson House have the potential to be affected. Thus, this plan of correction applies to those residents. Staffing ratios have been reviewed and updated. Going forward there will be 3 staff members scheduled on the night shift, to ensure that there is 1 staff member present in each building of the facility. The Business Office Manager/Human Resources Director (BOM/HRD) and the Scheduler were educated relative to the staffing ratio change. BOM/HRD, the Scheduler or designee, will be responsible for monitoring the schedule to ensure 3 staff members are scheduled on the night shift. The Scheduler, or designee, will	

	assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on observation, interview, and record review, the facility failed to ensure sufficient staff were present on site consistently for resident's individual needs. 38 of 38 residents resided in the facility. Findings include: A facility staffing schedule for 6/7/26-6/19/26, provided by the Business Office Manager (BOM) on 6/17/26 at 11:15 a.m., indicated the number of staff scheduled aftter 10 p.m for three buildings on the following dates: 6/7/26: 2 6/8/26: 2 6/9/26: 2 6/10/26: 2 6/11/26: 1 6/12/26: 2 6/13/26: 2 6/14/26: 2 6/15/26: 1 6/16/26: 2		be responsible for auditing the schedule daily, on scheduled days of work, for 4 weeks, and then twice weekly for 4 weeks to ensure continued compliance with ensuring staffing is correct. The Scheduler will provide results of their audits to the Director of Nursing. Any identified concerns will be addressed promptly with the responsible individual.	

	6/17/26: 2 6/18/26: 2 During an interview, on 6/18/26 at 1:22 a.m. one CNA was present in the Washington building. CNA 6 indicated they were the only employee present in the Washington building. At night, one employee was stationed in the Lincoln building. No one was scheduled to work in the Jefferson building overnight. When a resident in the Jefferson building needed assistance, an employee from the Lincoln building would have to leave that building and walk over to Jefferson. CNA 6 indicated they were unable to leave the Washington building unless they were relieved by another employee. The entrance and exit doors of the Washington and Jefferson Buildings lock after 8 p.m. every day and cannot be unlocked without a passcode. During an observation, on 6/18/26 at 1:34 a.m., no staff were present in the Jefferson building. All 3 exit doors were locked with keypads required for entry and exit. During an interview, on 6/18/26 at 1:45 a.m., QMA 7 indicated a total of two staff members were present on the current shift. She was stationed/remained in the Lincoln building on night shift			

	unless she left to answer a call light or pass medications in Jefferson building or Washington building. CNA 6 was assigned to the Washington building and remained in Washington builiding for the night shift.The call lights rang to the phones and a call light device in each building campus wide. No staff were scheduled to remain in the Jefferson building on night shift. During an observation, on 6/18/26 at 2:33 a.m., QMA 7 and QMA 8 entered Jefferson building and the lights were dim. No staff members were present in the building when the building was entered. On 6/18/25 at 2:45 a.m., QMA 8 indicated she was concerned for the safety of the ten residents who resided in Jefferson building because no staff remained in the building at night to assist with emergencies. There were times that call lights were activated in all three buildings at the same time. On 6/18/26 at 5:00 a.m., QMA 8 indicated she was going to Washington building and Jefferson building to pass medications. Lincoln building would not have a staff member present in the building while she was gone. QMA 8 then exited the front door of Lincoln			

	building. At 5:49 a.m., QMA 8 returned to Lincoln building after passing her medications in the other buildings. During an observation, on 6/19/26 from 12:10 p.m. to 12:14 p.m., the Maintenance Director measured the path taken on foot during night shift observations. The distance was 886 feet and 1 inch from the North front entrance of Jefferson building to the front main entrance of Lincoln building. A facility document titled, Employee Time Cards 6/7/2026-6/8/2026, provided by the BOM on 6/19/26 at 11:37 a.m., indicated on 6/7/26: CNA 12 worked 2:00 p.m.-2:00 a.m. and QMA 8 worked 6:00 p.m.-6:00 a.m. During a telephone interview, on 6/19/26 at 2:13 p.m., the Regional Director of Operations indicated there should be adequate staffing in the building, regardless of shift, to meet the residents needs. The facility had three buildings but was considered as one building. They had never been asked how residents in all three buildings would receive necessary assistance in a disaster event where all three buildings had injured residents and only two staff members were on campus. The plan			

	needed revisited. This citation relates to Intake 470112.			
R 0154	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(k) (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure dishes were properly sanitized related to availability and utilization of proper sanitizer test strips for the dishwasher. 38 of 38 residents ate meals prepared in the kitchen. Findings include: During a kitchen tour, on 6/17/26 at 11:13 a.m., the following concerns were observed: The low temperature dish washer temperatures were 108.6 degrees wash cycle and 124.1 degree sanitize cycle. A bucket of chlorine sanitizer was connected to the dishwasher machine. At 11:15 a.m., Dietary	R 0154	No residents were identified as experience adverse effects from this deficiency. Upon identification of the deficiency the facility moved to paper products until the proper test strips were delivered. The facility obtained and verified the appropriate and correct chlorine test strips. GFS rep verified the dish machine and appropriate sanitization. All 38 residents in the facility had the potential to be impacted by this deficiency. A review of the dietary sanitation process was completed. A Food Service Sanitation Policy was implemented, and dietary staff have been in-serviced. The culinary manager will complete weekly audits of the sanitation logs for 4 weeks and monthly for 2 months following. The culinary manager will ensure proper sanitation methods, proper sanitation testing methods, dishwasher logs maintained properly, and report any shortages of supplies to the Executive Director.	

	Aide 16 attempted to test the dishwasher sanitizer parts per million (ppm) with QT-40 (Quaternary) test strips. The result was 0 ppm. Dietary Aide 16 indicated she used the QT-40 strips for the dishwasher because she could not find the chlorine test strips. Dietary Aide 16 planned to get with Cook 15 to see if she could locate the chlorine test strips necessary for testing the dishwasher. The dishwasher remained in use. During a kitchen observation, on 6/19/26 at 10:45 a.m., Dietary Aide 16 had the same dishwasher running. She indicated she did not find any chlorine test strips since the kitchen observation on 6/17/26. The QT-40 test strips were the only test strips she had on hand. She had not been able to properly test the chlorine ppm during the dishwasher sanitize cycle to ensure dishes were properly sanitized without chlorine test strips The QT-40 test strips were not working. She confirmed the bucket of chemical ran through the dishwasher was labeled as chlorine. Dietary Aide 16 indicated the dishwasher logs had not been filled out at some meals since 6/17/26 because she did not have the chlorine test strips. She failed to let anyone know she was out of chlorine test strips for the			

	dishwasher. The "Dishmachine Temperature Log" was incomplete and lacked the following information on the following dates and meals: 6/14/26 - breakfast and dinner: no temperatures and no sanitizer ppm 6/15/26 - breakfast lunch and dinner: no temperatures and no sanitizer ppm 6/16/26 - breakfast lunch and dinner: no temperatures and no sanitizer ppm 6/17/26 - lunch: no temperatures and no sanitizer ppm 6/19/26 - breakfast: no temperature and no sanitizer ppm.			

	During an interview, on 6/19/26 at 10:53 a.m., Cook 15 indicated she was in charge of ordering while the Dietary Manager was out of the facility on vacation. No one notified her the kitchen was out of chlorine test strips for the dishwasher. The dishwasher was a low temperature dishwasher. Cook 15 was unable to ensure the dishes were properly sanitized for safe and sanitary food distribution without testing the dishwasher chlorine sanitizer ppm. During a telephone interview, on 6/19/26 at 2:13 p.m., the Regional Director of Operations indicated the proper test strips for the specific sanitizer was required for the dishwasher. All residents in the facility ate meals prepared in the facility kitchen. A dishwasher facility policy was not provided prior to facility exit on 6/19/26.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:	R 0217	No resident suffered negative outcome as a result of the cited practice. Residents residing in Lincoln and Jefferson House have the potential to be affected. Thus, this plan of correction applies to those residents.	

	(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure service plans were		Staffing ratios have been reviewed and updated. Going forward there will be 3 staff members scheduled on the night shift, to ensure that there is 1 staff member present in each building of the facility. The Business Office Manager/Human Resources Director (BOM/HRD) and the Scheduler were educated relative to the staffing ratio change. BOM/HRD, the Scheduler or designee, will be responsible for monitoring the schedule to ensure 3 staff members are scheduled on the night shift. The Scheduler, or designee, will be responsible for auditing the schedule daily, on scheduled days of work, for 4 weeks, and then twice weekly for 4 weeks to ensure continued compliance with ensuring staffing is correct. The Scheduler will provide results of their audits to the Director of Nursing. Any identified concerns will be addressed promptly with the responsible individual.	

	signed by the resident or their representative for 3 of 7 residents reviewed for service plans. (Residents 3, 4, and 40) Findings include: 1. Resident 40's record was reviewed 6/17/26 at 1:42 p.m. Medical diagnoses included respiratory failure, chronic obstructive pulmonary disease (COPD), and insomnia. A 3/27/26, Quarterly Service Plan indicated the resident was moderately cognitively impaired. The service plan was not signed by the resident or their representative. 2. Resident 3's record was reviewed on 6/17/26 at 2:20 p.m. Medical diagnoses included COPD, chronic kidney disease, and hypertension. A 3/27/26, Quarterly Service Plan indicated the resident was cognitively intact. The service plan was not signed by the resident of their representative. 3. Resident 4's record was reviewed on 6/18/26 at 3:22 a.m. Medical diagnoses included dementia, asthma, COPD, and hypertension. A 3/12/26, Initial Service Plan indicated the resident was severely cognitively impaired. The service plan was not signed			

	by the resident or their representative. During an interview, on 6/19/26 at 11:52 a.m., the DON indicated service plans for Resident 3, Resident 4, and Residnet 40 were not signed by the resident or their representative. All service plans should be reviewed and signed by the resident or their representatives. A current facility policy titled, "Service Plan", revised 3/2026, and provided by the DON on 6/19/26 at 10:26 a.m., indicated the following: " ...Procedure: Service plans shall be developed and reviewed for each resident upon admission (within 30 days) to the facility ...Service plans shall be reviewed and updated according to the following guidelines: ...At any significant change in condition, function level, medical status, and/or service needs ...." The policy lacked with whom the service plan should be developed and reviewed.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents	R 0273	No residents were identified as having adverse effects related to this deficient practice. Upon identification, all identified expired, spoiled, undated, unlabeled, and/or contaminated foods were immediately disposed of. The	

	' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to store and distribute foods under safe sanitary conditions regarding, dating and labeling foods, foods exposed to air, and disposal of outdated items. 38 of 38 residents who ate meals prepared in the facility kitchen. Findings include: During a kitchen tour on 6/17/26 at 10:45 a.m., the following concerns were observed: The walk-in refrigerator had undated and unlabeled foods as follows: A open bag of hard salami unsealed and open to air/contaminants identified as salami with no opened date, an opened storage bag of of ham identified as ham with no opened date, a storage bag of deli meat identified as turkey with no opened date, a storage bag of small round meat identified as pepperoni with no opened date. All of these items were inside a plastic tub. There were two- 6 ounce (oz.) clean containers of red raspberries covered with a fuzzy white/green substance, two - 6 oz. clear containers of blackberries covered with a		refrigerator was cleaned to ensure food items are being stored in a safe and sanitary manner. All 38 residents that reside in the facility were defined as potentially impacted. A complete inspection of facility food storage was completed. Facility food storage and procurement policies were updated to ensure proper guidance. Dietary staff were in-serviced on the updated policies/procedures. The dietary manager will perform daily refrigerator audits for 2 weeks and weekly audits for 6 weeks directly after. The dietary manager will ensure all items are properly labeled and dated, no expired or contaminated foods are stored and/or served, leftovers are properly dated, stored, and discarded, and staff compliances will policies and procedures.	

	fuzzy white/green substance. The foods were identified by Cook 15. She indicated she was uncertain when these items were opened or last served. The fuzzy white/green substance on the fruit was identified as mold. The items should not have been left in the refrigerator. The walk-in refrigerator had left-over food items undated when prepared as follows: a storage bag of yellow moon shaped items identified as omelets unlabeled and undated when prepared, and a storage bag of seven garlic cheddar biscuits. Cook 15 indicated left over foods could be held for three days. She was uncertain when these items were prepared or last served. They should have been disposed of. These items should not have been left in the refrigerator. The walk- in refrigerator had the following dairy products expired beyond the manufacturer dates: 6 - 5 pound (lbs.) containers of small curd cottage cheese with a manufacturer best by date of 6/10/26 (one was opened and undated when opened), one - 5 lbs. container of sour cream with a manufacturer best by date of 6/13/26 (opened and undated when opened). During an interview, on 6/17/26 at 11:05 a.m., Cook 15			

	indicated she was aware the dietary staff had items unlabeled, undated, and expired because they had some meetings about it. She thought the problem had improved. All dietary staff were to respond to and check for expired, undated, and unlabeled dietary items in the refrigerator and dispose of them immediately. She typically checked at the beginning of her shift for these types of items, but they must have been missed. The left over policy was three days but one would not know how many days the left overs were in the refrigerator when they were not dated. Expired items should have been removed immediately upon expiration. During a telephone interview, on 6/19/26 at 2:13 p.m., the Regional Director of Operations indicated dietary items were required to be covered to prevent exposure to air, leftovers dated and labeled, and dietary items dated and labeled when opened. Dairy products should not be used after the manufacturer expiration date and required timely disposal as well as fruits with mold. A policy for food storage and labeling related to food items open to air, expired dairy products, and undated open items was not provided prior to			

	facility exit. A policy for leftovers was not provided prior to facility exit.			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to ensure residents received tuberculosis testing on admission for 5 of 7 residents	R 0410	Resident #s 40, 3, 4, B, and C had PPDs administered at the time of the survey. All residents admitted to the facility have the potential to be affected. An audit of all residents has been conducted to determine any residents who did not receive a 2-step PPD upon admission. Those residents identified have been administered a 2-step PPD. The DON was re-educated relative to Infection Control, including but not limited to, tuberculin test requirements. The Regional Director of Clinical Services (RDCS), or designee, shall be responsible for auditing the charts of new admissions to ensure 2-step PPDs are administered and documented. Audits of newly admitted resident charts will be conducted weekly for 4 weeks, and then biweekly for 4 weeks. Any identified concerns will be promptly addressed with the DON.	

reviewed. (Residents 3, 4, 40, B, and C)

Findings include:

1.Resident 40 's record was reviewed on 6/17/26 at 1:42 p.m. Medical diagnoses included respiratory failure, chronic obstructive pulmonary disease (COPD), and insomnia. The record lacked tuberculosis testing on admission

2. Resident 3's record was reviewed on 6/17/26 at 2:20 p.m. Medical diagnoses included COPD, chronic kidney disease, and hypertension. The record lacked tuberculosis testing on admission.

3. Resident 4's record was reviewed on 6/18/26 at 3:22 a.m. Medical diagnoses included dementia, asthma, COPD, and hypertension. The record lacked tuberculosis testing on admission.

4. .Resident B ' s record was reviewed on 6/18/26 at 4:58 a..m. Medical diagnoses included Parkinsonism, transischemic attack (TIA), and rheumatoid arthritis. The record lacked tuberculosis testing on admission.

5. Resident C ' s record was reviewed on 6/18/26 at 7:19 a.m. Medical diagnoses included dementia,

rhabdomyolysis, and osteoarthritis. The record lacked tuberculosis testing on admission.

During an interview, on 6/19/26 at 12:13 p.m., the DON indicated Resident 3, Resident 4, Resident 40, Resident B, and Resident C did not have tuberculosis testing performed at or prior to admission. All incoming residents should have been tested for tuberculosis prior to or on admission to the facility.

A current facility policy, revised 3/2026, titled " PPD Policy," provided by the DON on 6/19/26 at 12:40 p.m., indicated the following: " Purpose: To identify, assess, and reduce the risk of Tuberculosis (TB) transmission within the Residential, Care Facility and to ensure compliance with Indiana Department of Health (IDOH) requirements and applicable Indiana Medicaid standards ...Resident Screening- Residents shall be screened for signs and symptoms of TB upon admission and as clinically indicated ...Documentation- TB risk assessments, screenings, exposures, and corrective actions shall be documented and maintained by the facility .... "

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURESavannah Corner	TITLERDO	(X6) DATE07/08/2026