

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2025	
NAME OF PROVIDER OR SUPPLIER HERITAGE ASSISTED LIVING OF YORKTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 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 the Investigation of Complaints IN00455204, IN00454796, IN00454482, IN00453997, IN00453923, IN00453810, IN00453578, IN00453610, and IN00453358. Complaint IN00455204 - State deficiencies related to the allegations are cited at R0121. Complaint IN00454796 - No deficiencies related to the allegations are cited. Complaint IN00454482 - No deficiencies related to the allegations are cited. Complaint IN00453997 - State deficiencies related to the allegations are cited at R0349. Complaint IN00453923 - No deficiencies related to the allegations are cited. Complaint IN00453810 - No deficiencies related to the	R 0000					

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	allegations are cited. Complaint IN00453578 - No deficiencies related to the allegations are cited. Complaint IN00453610 - No deficiencies related to the allegations are cited. Complaint IN00453358 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: March 10, 11, and 12, 2024 Facility number: 014281 Residential Census: 23 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 21, 2025.			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the	R 0121	All residents had the potential to be affected by this alleged deficient practiceThe BOM or designee will perform an audit of personnel files to ensure all current employees have been given tuberculosis testing, or chest x ray if applicable DON or designee will ensure future employees have completed TB test or Chest X ray completed prior to scheduling to work.	04/12/2025

date given, date read, and by whom administered. The facility must assure the following:

(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers 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 one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.

(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.

(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.

(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.

Based on observation, interview

All new hires will be put on white board in DON office to ensure 1st and 2nd step dates noted

All new hires will be audited weekly for 4 weeks, bi-weekly for 2 months, then monthly for 3 months until 100% compliance is achieved

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and record review, the facility failed to implement regulatory guidelines for tuberculosis testing of new employees for 7 of 9 direct care employees reviewed to tuberculosis screening. (CNA 1, CNA 2, CNA 3, CNA 4, CNA 7, RN 8 and QMA 5).

Findings include:

Review of Employee Records was completed on 3/12/25 and the following observed:

CNA 1 hired on 1/21/25, CNA 2 hired on 12/5/24, CNA 3 hired on 12/6/25, CNA 4 hired on 1/21/25, CNA 7 hired on 12/12/24, RN 8 hired on 12/4/24, and QMA 5 hired on 1/21/25. Each staff member received a first step PPD upon hire, but did not received a second step PPD. The records lacked documentation of tuberculosis skin testing prior to date of hire.

During an interview on 3/11/25 at 2:03 p.m., the Regional Finance Director, Regional Director of Nursing, and the DON indicated the facility had an interim DON who was responsible for overseeing the new hire process. The facility was unaware the tuberculosis screening had not been completed.

A current undated policy titled, "Personnel Policy," was

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provided by the DON on 3/12/25 at 2:49 p.m., included the following:

" 1. Employee File Documentation Requirements

A provider shall maintain a complete and accurate personnel file for each employee or agent. The file must be kept in the provider's office and include all necessary documentation based on whether the employee or agent provides direct care services.

2. Direct Care Employee File Requirements:

The personnel file for employees or agents who provide direct care services must contain, at a minimum, the following documents:

An annual negative tuberculin skin test or chest x-ray, updated in accordance with the Centers for Disease Control (CDC) guidelines, prior to providing direct care services.

7. Health Screening Requirements for Direct Care Staff

Tuberculosis (TB) Screening: All direct care staff must provide verification of a negative TB test or a negative chest x-ray prior to employment. Results must be no more than 30 days old.".
The policy did not contain

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information related the new hire first and second step tuberculin screening."

This citation relates to complaint IN00455204.

Based on observation, interview and record review, the facility failed to implement regulatory guidelines for tuberculosis testing of new employees for 7 of 9 direct care employees reviewed to tuberculosis screening. (CNA 1, CNA 2, CNA 3, CNA 4, CNA 7, RN 8 and QMA 5).

Findings include:

Review of Employee Records was completed on 3/12/25 and the following observed:

CNA 1 hired on 1/21/25, CNA 2 hired on 12/5/24, CNA 3 hired on 12/6/25, CNA 4 hired on 1/21/25, CNA 7 hired on 12/12/24, RN 8 hired on 12/4/24, and QMA 5 hired on 1/21/25. Each staff member received a first step PPD upon hire, but did not received a second step PPD. The records lacked documentation of tuberculosis skin testing prior to date of hire.

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The personnel file for employees or agents who provide direct care services must contain, at a minimum, the following documents:

An annual negative tuberculin skin test or chest x-ray, updated in accordance with the Centers for Disease Control (CDC) guidelines, prior to providing direct care services.

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	7. Health Screening Requirements for Direct Care Staff Tuberculosis (TB) Screening: All direct care staff must provide verification of a negative TB test or a negative chest x-ray prior to employment. Results must be no more than 30 days old.". The policy did not contain information related the new hire first and second step tuberculin screening." This citation relates to complaint IN00455204.			
R 0185	Physical Plant Standards - Noncompliance 410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E) (i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire marshal. The facility shall: (1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms below ground level for resident occupancy if the floors are not more than three (3) feet below ground level. (2) Provide each resident the following items upon request at the time of admission: (A) A bed:	R 0185	All Residents have the potential to be affected by this alleged deficient practice All residents have working call light pendants DON will provide in-service to staff to educate on call pendant policy and safety. Company is actively seeking other call light options to provide an alternate way for residents to reach out for assistance in addition to pendants. DON or designee will perform audits to ensure pendant placement is either worn or within reach of all residents Audits will be performed on 5 residents each week for 4 weeks, then bi-weekly for 2 months, then	04/12/2025

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(i) of appropriate size and height for the resident; (ii) with a clean and comfortable mattress; and (iii) with comfortable bedding appropriate to the temperature of the facility. (B) A bedside cabinet or table with a hard surface and washable top. (C) A cushioned comfortable chair. (D) A bedside lamp. (E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device. (3) Provide cubicle curtains or screens if requested by a resident in a shared room. (4) Provide a method by which each resident may summon a staff person at any time. (5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area. (6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare. (7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall have clothing storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped		monthly for 3 months	
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with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs.

Based on observation and interview, the facility failed to ensure that cognitively impaired residents, living in a secured unit, had a method by which to always summon staff for assistance for 3 of 5 residents reviewed for safety. (Resident B, Resident E, Resident F)

Findings include:

During observations on 3/10/25 during the lunch service and on 3/11/25 at 9:33 a.m., Resident D was observed sitting at a table in the common area alone. The resident was not wearing a call pendant.

During an observation on 3/11/25 at 9:25 a.m., Resident B was sitting at a table in their room while eating breakfast. The resident was not wearing a call pendant and indicated she did not know where it was located. The DON came to the room and located the pendant. The DON indicated the pendant was in the resident's belongings that were sent from the hospital the previous night. The resident was without a method to call for assistance from 3/10/25 at 9:30 p.m. to 3/11/225 at 9:25 a.m. The room was checked for

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alternate methods to call for assistance. No other call system was present.

During an observation on 3/11/25 at 9:33 a.m., Resident E was observed in the common area. The resident was not wearing a call pendant.

During an observation on 3/11/25 at 9:47 a.m., Resident F was observed sitting in common area for breakfast. The resident was not wearing a call pendant.

During an interview on 3/11/25 at 11:05 a.m., QMA 9 indicated all residents had pendants to use to call for assistance. None of the resident rooms were equipped with other methods to call for assistance.

During an interview on 3/12/25 at 11:17 a.m., the DON indicated staff should have been making sure the residents were wearing the pendant in order to call for assistance if needed. The DON indicated the facility recognized the need for another type of call system due to residents with dementia not always wanted to or forgot to wear the pendant.

A current undated policy titled "Call Pendant Policy & Procedure" was provided by the DON on 3/12/25 at 2:49 p.m. The policy indicated the following:

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" 5) When leaving the resident, the employee shall ensure the pendant is within reach and accessible of the resident."

Based on observation and interview, the facility failed to ensure that cognitively impaired residents, living in a secured unit, had a method by which to always summon staff for assistance for 3 of 5 residents reviewed for safety. (Resident B, Resident E, Resident F)

Findings include:

During observations on 3/10/25 during the lunch service and on 3/11/25 at 9:33 a.m., Resident D was observed sitting at a table in the common area alone. The resident was not wearing a call pendant.

During an observation on 3/11/25 at 9:25 a.m., Resident B was sitting at a table in their room while eating breakfast. The resident was not wearing a call pendant and indicated she did not know where it was located. The DON came to the room and located the pendant. The DON indicated the pendant was in the resident's belongings that were sent from the hospital the previous night. The resident was without a method to call for assistance from 3/10/25 at 9:30 p.m. to 3/11/225 at 9:25 a.m. The room was checked for

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alternate methods to call for assistance. No other call system was present.

During an observation on 3/11/25 at 9:33 a.m., Resident E was observed in the common area. The resident was not wearing a call pendant.

During an observation on 3/11/25 at 9:47 a.m., Resident F was observed sitting in common area for breakfast. The resident was not wearing a call pendant.

During an interview on 3/11/25 at 11:05 a.m., QMA 9 indicated all residents had pendants to use to call for assistance. None of the resident rooms were equipped with other methods to call for assistance.

During an interview on 3/12/25 at 11:17 a.m., the DON indicated staff should have been making sure the residents were wearing the pendant in order to call for assistance if needed. The DON indicated the facility recognized the need for another type of call system due to residents with dementia not always wanted to or forgot to wear the pendant.

A current undated policy titled "Call Pendant Policy & Procedure" was provided by the DON on 3/12/25 at 2:49 p.m. The policy indicated the following:

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	" 5) When leaving the resident, the employee shall ensure the pendant is within reach and accessible of the resident."			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure complete and accurate clinical records related to an undocumented fall of a cognitively impaired resident (Resident C) for 1 of 3 residents reviewed for falls. Findings include: Resident C's clinical record was reviewed on 3/11/25 at 9:44 a.m. Diagnoses included Alzheimer's disease, osteoporosis, anemia, asthma, cardiomyopathy, chronic kidney disease, dementia,	R 0349	All Residents have the potential to be affected by this alleged deficient practice. DON or designee will review all fall events in daily clinical meetings DON or designee will provide In-service to clinical staff to provide education regarding falls policy and documentation. DON or designee will monitor to ensure documentation and follow-up is completed, post-fall events, weekly for 4 weeks, then bi-weekly for 2 weeks, then monthly for 3 months.	04/12/2025

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FORM APPROVED

OMB NO. 0938-0391

hypothyroidism, overactive bladder, osteoarthritis, type 2 diabetes, and congestive heart failure. The resident was assessed with severe cognitive impairment.

During an interview on 3/12/25 at 10:17 a.m., Resident C's family member indicated, on 3/9/25, they received a call from another family member who had witnessed the resident sliding from the recliner to the floor via the camera. The family member unsuccessfully attempted to reach the facility by phone and drove to the facility. The family member indicated the resident was on the floor for 45 minutes. The family member indicated the family had installed a camera in the resident's room for periodic observation.

During an interview on 3/12/25 at 11:54 a.m., QMA 10 indicated they were in the other building to pass medications when notified of Resident C's fall by CNA 11. QMA 10 indicated they went to the resident's room and found the resident sitting on the floor and CNA 11 was present. After taking the resident's vitals, QMA 10 called the DON to report the fall. QMA 10 indicated the incident was not documented in the clinical record because they had never been educated on how to document in the progress notes or do incident reporting. QMA

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10 was an agency staff member, however this was not their first time working for this facility.

During an interview on 3/12/25 at 11:17 a.m., the DON indicated she had been called on 3/9/25 at approximately 12:30 p.m. by QMA 10. She was notified that Resident C had slid from her recliner and the family and doctor were aware. The DON indicated the fall should have been documented in the clinical record. The agency staff had been educated on how to document in the electronic record.

The clinical record lacked documentation related to the resident's fall on 3/9/25.

A current undated policy titled, "Incident Reporting," provided by the DON on 3/12/25 at 2:49 p.m., indicated the following:

" POLICY: Any incident or unusual occurrence involving a resident, worker, visitor or vendor, or physical damage to Community property and/or vehicles is reported in full.

Definition:

An injury, or any occurrence which might have a potential adverse effect on any resident, including: exit seeking behavior, resident- to -resident contact; a fall, fracture, skin tear, burn or

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laceration; choking; missed or inaccurate medication; suspected abuse; outbreaks of communicable illness; and other similar events."

This citation relates to Complaint IN00453997.

Based on interview and record review, the facility failed to ensure complete and accurate clinical records related to an undocumented fall of a cognitively impaired resident (Resident C) for 1 of 3 residents reviewed for falls.

Findings include:

Resident C's clinical record was reviewed on 3/11/25 at 9:44 a.m. Diagnoses included Alzheimer's disease, osteoporosis, anemia, asthma, cardiomyopathy, chronic kidney disease, dementia, hypothyroidism, overactive bladder, osteoarthritis, type 2 diabetes, and congestive heart failure. The resident was assessed with severe cognitive impairment.

During an interview on 3/12/25 at 10:17 a.m., Resident C's family member indicated, on 3/9/25, they received a call from another family member who had witnessed the resident sliding from the recliner to the floor via the camera. The family member unsuccessfully attempted to reach the facility by phone and

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drove to the facility. The family member indicated the resident was on the floor for 45 minutes. The family member indicated the family had installed a camera in the resident's room for periodic observation.

During an interview on 3/12/25 at 11:54 a.m., QMA 10 indicated they were in the other building to pass medications when notified of Resident C's fall by CNA 11. QMA 10 indicated they went to the resident's room and found the resident sitting on the floor and CNA 11 was present. After taking the resident's vitals, QMA 10 called the DON to report the fall. QMA 10 indicated the incident was not documented in the clinical record because they had never been educated on how to document in the progress notes or do incident reporting. QMA 10 was an agency staff member, however this was not their first time working for this facility.

During an interview on 3/12/25 at 11:17 a.m., the DON indicated she had been called on 3/9/25 at approximately 12:30 p.m. by QMA 10. She was notified that Resident C had slid from her recliner and the family and doctor were aware. The DON indicated the fall should have been documented in the clinical record. The agency staff had been educated on how to

document in the electronic record.

The clinical record lacked documentation related to the resident's fall on 3/9/25.

A current undated policy titled, "Incident Reporting," provided by the DON on 3/12/25 at 2:49 p.m., indicated the following:

" POLICY: Any incident or unusual occurrence involving a resident, worker, visitor or vendor, or physical damage to Community property and/or vehicles is reported in full.

Definition:

An injury, or any occurrence which might have a potential adverse effect on any resident, including: exit seeking behavior, resident- to -resident contact; a fall, fracture, skin tear, burn or laceration; choking; missed or inaccurate medication; suspected abuse; outbreaks of communicable illness; and other similar events."

This citation relates to Complaint IN00453997.

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
SIGNATURE

TITLE

(X6) DATE