STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/17/2025

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. Survey dates: 7/16/25 and 7/17/25 Facility number: 014281 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 21, 2025.	R 0000	This Plan of Correction is submitted in response to the Statement of Deficiencies issued following the recent survey of Heritage Assisted Living of Yorktown. This Plan of Correction outlines the measures that will be implemented to address the cited deficiencies and ensure ongoing compliance with all applicable regulations. *Note: The submission of this Plan of Correction does not constitute an admission or agreement by Heritage Assisted Living of Yorktown, with the facts alleged or the conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and submitted solely to meet the requirements of state and federal law.*	
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:	R 0088	• No residents were affected by this deficient practice of delayed notification, and the change in Administration did not disrupt the care or services provided by the facility. • While all Residents had the	08/08/2025

	(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 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 interview and record review, the facility failed to notify the Indiana Department of Health (IDOH) of a change in the Administrator of record within the required timeframe. Finding includes: Review of the pre-survey report, dated 7/3/25, indicated Administrator B as the current administrator of record for the facility. During an interview on 7/16/25 at 12:30 p.m., Administrator C indicated she had been the Administrator since April 2025. On 7/17/25 at 12:34 p.m.,		potential to be affected by this deficient practice, the Administrator of record was updated and submitted to the Indiana State Department of Health while surveyor was on-site. A copy was presented to the surveyor. • Business Office Manager to monitor Licensure book and audit monthly. Education provided to the Business Office Manager regarding submission of change form to the ISDH. • Business Office Manager or Designee will audit licensure book weekly for 1 month, then monthly thereafter. Licensure book will be brought to quarterly QA meetings to ensure compliance.	

	Administrator C indicated she would look for the notification of change in Administration form provided to the IDOH. On 7/17/25 at 1:20 p.m., Administrator C indicated the facility failed to notify IDOH of a change in the administrator of record. This should have been submitted in April 2025. A request was made of Administrator C for a policy regarding State notification of a change in administration. Employee records reviewed on 7/17/25 at 1:38 p.m. indicated the Administrator began working for the facility on 4/4/25. A policy for change in administrator was not provided prior to facility exit on 7/17/25 at 4:45 p.m. Based on interview and record review, the facility failed to notify the Indiana Department of Health (IDOH) of a change in the Administrator of record within the required timeframe. Finding includes: Review of the pre-survey report, dated 7/3/25, indicated Administrator B as the current administrator of record for the facility. During an interview on 7/16/25 at 12:30 p.m., Administrator C indicated she had been the			

	Administrator since April 2025. On 7/17/25 at 12:34 p.m., Administrator C indicated she would look for the notification of change in Administration form provided to the IDOH. On 7/17/25 at 1:20 p.m., Administrator C indicated the facility failed to notify IDOH of a change in the administrator of record. This should have been submitted in April 2025. A request was made of Administrator C for a policy regarding State notification of a change in administration. Employee records reviewed on 7/17/25 at 1:38 p.m. indicated the Administrator began working for the facility on 4/4/25. A policy for change in administrator was not provided prior to facility exit on 7/17/25 at 4:45 p.m.			
R 0095	Administration and Management -Noncompliance 410 IAC 16.2-5-1.3(l)(1-2) (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social	R 0095	• 11 residents were affected by this deficient practice of delayed submission of the Alzheimer's Special Care Unit Disclosure form to the ISDH. No Residents were negatively impacted. • No other Residents were affected by this alleged deficient practice. The late submission of the Alzheimer's Special Care Unit Disclosure form	08/08/2025

	service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on interview and record review, the facility failed to submit an Indiana Dementia Disclosure form within the required timeframe. This deficient practice affected 11 residents residing on the secured unit. Finding includes: During an interview with the Administrator on 7/16/25 at 12:23 p.m., she indicated she was unsure when the last Dementia Disclosure form was		did not disrupt the care or services provided by the facility. Disclosure was submitted in August of 2024 and will be re submitted in December of 2025. • Administrator and Regional Director of Operations or Designees will ensure that the annual Disclosure form is completed and submitted timely by performing compliance audits and adding to Outlook calendar • Administrator or Designee will perform monthly for 12 months, to ensure timely submission of required forms to ISDH	

	completed and submitted to the required State Agency. An Indiana Dementia Disclosure form provided by the Administrator on 7/17/25 at 1:31 p.m. indicated it was submitted on 4/24/24. Review of a facility census report indicated 11 residents resided on the secured unit. During an interview with the Administrator on 7/17/25 at 2:00 p.m. she indicated she was unable to recall when the Dementia Disclosure form was submitted and indicated the form should have been submitted in December 2024. A facility policy regarding Dementia Disclosure submission was requested of the Administrator. No policy or further information was provided prior to exit on 7/17/25 at 4:45 p.m. Based on interview and record review, the facility failed to submit an Indiana Dementia Disclosure form within the required timeframe. This deficient practice affected 11 residents residing on the secured unit. Finding includes: During an interview with the Administrator on 7/16/25 at 12:23 p.m., she indicated she			

	was unsure when the last Dementia Disclosure form was completed and submitted to the required State Agency. An Indiana Dementia Disclosure form provided by the Administrator on 7/17/25 at 1:31 p.m. indicated it was submitted on 4/24/24. Review of a facility census report indicated 11 residents resided on the secured unit. During an interview with the Administrator on 7/17/25 at 2:00 p.m. she indicated she was unable to recall when the Dementia Disclosure form was submitted and indicated the form should have been submitted in December 2024. A facility policy regarding Dementia Disclosure submission was requested of the Administrator. No policy or further information was provided prior to exit on 7/17/25 at 4:45 p.m.			
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	• 6 Residents were affected by this alleged deficient practice. The 6 unsigned Service Plans have been signed by the Resident or Representative. • No other Residents were affected by this alleged deficient practice. DON audited all other resident profiles to assure	08/08/2025

	(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 signed by residents or their		Service Plans were signed, with no other concerns noted • DON or Designee will complete ongoing audits to ensure service plans are appropriate, reviewed and signed by the Resident or Resident Representative, weekly for 4 weeks, then monthly for 6 months. • Audits to be brought to quarterly QA meetings to ensure compliance	

representatives for 5 of 7 residents (Residents 12, 18, 10, 30, and 2) and failed to develop a service plan for 1 of 7 residents (Resident 9) reviewed for service plans.

Finding includes:

1. Resident 12's record was reviewed on 7/16/25 at 2:51 p.m. Diagnoses included Alzheimer's disease, diabetes, and diverticulitis (inflammation of the large intestine). A service plan dated 3/12/25 lacked a signature from the resident or their representative.

2. Resident 18's record was reviewed on 7/16/25 at 3:08 p.m. Diagnoses included difficulty in walking, bipolar disorder, and atrial fibrillation (abnormal heart rhythm). A service plan dated 3/11/25 lacked a signature from the resident or their representative.

3. Resident 10's record was reviewed on 7/16/25 at 3:32 p.m. Diagnoses included Alzheimer's disease, bipolar disorder, and anxiety. A service plan dated 2/15/25 lacked a signature from the resident or their representative.

4. Resident 30's record was reviewed on 7/17/25 at 12:40 p.m. Diagnoses included Alzheimer's disease, hyperlipidemia and hypertension. A service plan

dated 2/15/25 lacked a signature from the resident or their representative.

5. Resident 2's record was reviewed on 7/17/25 at 1:55 p.m. Diagnoses included congestive heart failure, chronic kidney disease, and hypertension. A service plan dated 2/15/25 lacked a signature from the resident or their representative.

6. Resident 9's record was reviewed on 7/17/25 at 9:32 a.m. Diagnoses included stroke, hypertension, and atrial fibrillation. The clinical record lacked a service plan.

During an interview with the Administrator on 7/17/25 at 1:20 p.m. she indicated the facility did not have a policy regarding signed service plan, but followed state regulations. She indicated service plans were required to be signed by the resident or their representative.

Based on interview and record review, the facility failed to ensure service plans were signed by residents or their representatives for 5 of 7 residents (Residents 12, 18, 10, 30, and 2) and failed to develop a service plan for 1 of 7 residents (Resident 9) reviewed for service plans.

Finding includes:

	1. Resident 12's record was reviewed on 7/16/25 at 2:51 p.m. Diagnoses included Alzheimer's disease, diabetes, and diverticulitis (inflammation of the large intestine). A service plan dated 3/12/25 lacked a signature from the resident or their representative. 2. Resident 18's record was reviewed on 7/16/25 at 3:08 p.m. Diagnoses included difficulty in walking, bipolar disorder, and atrial fibrillation (abnormal heart rhythm). A service plan dated 3/11/25 lacked a signature from the resident or their representative. 3. Resident 10's record was reviewed on 7/16/25 at 3:32 p.m. Diagnoses included Alzheimer's disease, bipolar disorder, and anxiety. A service plan dated 2/15/25 lacked a signature from the resident or their representative. 4. Resident 30's record was reviewed on 7/17/25 at 12:40 p.m. Diagnoses included Alzheimer's disease, hyperlipidemia and hypertension. A service plan dated 2/15/25 lacked a signature from the resident or their representative. 5. Resident 2's record was reviewed on 7/17/25 at 1:55 p.m. Diagnoses included congestive heart failure, chronic			

	kidney disease, and hypertension. A service plan dated 2/15/25 lacked a signature from the resident or their representative. 6. Resident 9's record was reviewed on 7/17/25 at 9:32 a.m. Diagnoses included stroke, hypertension, and atrial fibrillation. The clinical record lacked a service plan. During an interview with the Administrator on 7/17/25 at 1:20 p.m. she indicated the facility did not have a policy regarding signed service plan, but followed state regulations. She indicated service plans were required to be signed by the resident or their representative.			

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