STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/17/2025

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 the Investigation of Complaints IN00461573 and IN00458918. Complaint IN00461573 - No deficiencies related to the allegations are cited. Complaint IN00458918 - State deficiencies related to the allegations are cited at R0052, R090, and R243. Survey date: June 16 and 17, 2025 Facility number: 014281 Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 19, 2025.	R 0000	Please accept this plan of correction as our measure of compliance to the alleged deficiencies. Our date of compliance will be 7/14/2025. We respectfully request a desk review in lieu of an onsite revisit	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6)	R 0052	While the facility self-reported	07/14/2025

	(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 prevent resident neglect when a staff member refused to administer scheduled pain medication due to the resident declining to use the bathroom. (Resident B and QMA 1). Findings include: Resident B's clinical record was reviewed on 6/16/25 at 10:54 a.m. Diagnoses included adult failure to thrive, hyperlipidemia, narcolepsy, chronic pain, hypertension, asthma, gastro-esophageal reflex disease. psoriatic arthritis, rheumatoid arthritis, overactive bladder, and chronic fatigue. Medication orders included oxycodone/APAP (opioid analgesic) 10-325 scheduled 4 (four) times a day, dated 2/26/25. A facility self-reportable incident,		the incident to the state dept of health, all residents had the potential to be affected by this deficient practice. Resident B was followed for psycho-social wellbeing with no adverse effects. All (interview able) residents were interviewed regarding receiving their pain medications with no concerns noted. Residents were encouraged to report to the DON or ED, should they not receive their pain medications. All nursing staff interviewed regarding knowledge of abuse with no other concerns noted. Staff re educated regarding abuse protocol, types of abuse and reporting protocol. QMA 2 praised for reporting the abuse All staff educated regarding recognizing different types of abuse and how to report per protocol. ED or designee will perform resident interview audits weekly	

	dated 5/5/25, indicated on 5/4/25 at approximately 5:09 a.m., QMA 1 refused to administer a scheduled pain medication to a resident because the resident refused to get up. During an interview on 6/16/25 at 11:16 a.m. QMA 2 indicated on 5/4/25 at approximately 5:09 a.m., QMA 1 sent a text message and indicated they had withheld Resident B's scheduled pain medication because the resident refused to get up. QMA 2 indicated they arrived to the facility around 6:00 a.m. and took report from QMA 1. After QMA 1 left the facility, QMA 2 text the DON and told her about the incident. QMA 1 was unable to be reached for interview during the survey. Review of a screen shot of the text message sent by QMA 1 to QMA 2, dated 5/4/2025 at 5:09 a.m., indicated QMA 1 pulled Resident B's scheduled "pain pill" but did not administer it because the resident refused to get up. "I have (name of Resident B) pain pill pulled but she is refusing to get up and go to the bathroom so if she don't get up for us I told her I wouldn't give her the pain pill because in all actuality it's a 6 am [sic] med and I don't have to give it cause I leave at that time she the		for 4 weeks, then monthly for 3 months, to ensure pain medications are being properly and timely given.	

	proceeded to tell me she's not going to make deals with her pain medication and I told her whichever she wants to do if she don't wanna get up out the bed and get changed out her wet brief then I will not be giving her that you can give it to her when you have time which will be probably 7-8 am [sic] I'm not sure so I'm leaving it up to her cause I'm not playing her games if she's asleep wants to be lazy and lay in a wet brief and sleep then you can give the medicine when you have time. I'm not gonna argue with her and reward her for being lazy I told her if she's asleep want gets up to let me know by ringing her bell and when she is changed I'll give it then after she gets outta her wet brief I think they need to lower that oxy cause when she's f - - - ked up and high off them she wants to be lazy as f - - k smh [shaking my head]. How do you guys deal with her being lazy like that throughout the day?" Review of time sheets for QMA 1, dated 5/3/25-5/4/25, indicated QMA 1 clocked in on 5/3/2025 at 7:05 p.m. and clocked out on 5/4/2025 at 6:15 a.m. A current undated policy, titled "Abuse, Neglect, and Misappropriation Policy & Procedure" was provided by the Administrator on 6/16/25 at 10:11 a.m. The policy indicated			

	the following: ".... Policy: Dependent Adult Abuse Prevention and Notification All employees of health care facilities are considered "mandatory abuse reporters" under Indiana law. An employee, who, during his or her employment, examines, attend, counsels, or treats a dependent adult and reasonably believes that the adult has suffered adult abuse, mist immediately report the allegations to the Director of Nursing. The Director of Nursing is responsible for immediately reporting allegations of abuse to the Executive Director, or designated facility abuse coordinator. ...." This citation relates to Complaint IN00458918. Based on record review and interview, the facility failed to prevent resident neglect when a staff member refused to administer scheduled pain medication due to the resident declining to use the bathroom. (Resident B and QMA 1). Findings include: Resident B's clinical record was reviewed on 6/16/25 at 10:54 a.m. Diagnoses included adult failure to thrive, hyperlipidemia, narcolepsy, chronic pain, hypertension, asthma, gastro-esophageal reflex			

	disease. psoriatic arthritis, rheumatoid arthritis, overactive bladder, and chronic fatigue. Medication orders included oxycodone/APAP (opioid analgesic) 10-325 scheduled 4 (four) times a day, dated 2/26/25. A facility self-reportable incident, dated 5/5/25, indicated on 5/4/25 at approximately 5:09 a.m., QMA 1 refused to administer a scheduled pain medication to a resident because the resident refused to get up. During an interview on 6/16/25 at 11:16 a.m. QMA 2 indicated on 5/4/25 at approximately 5:09 a.m., QMA 1 sent a text message and indicated they had withheld Resident B's scheduled pain medication because the resident refused to get up. QMA 2 indicated they arrived to the facility around 6:00 a.m. and took report from QMA 1. After QMA 1 left the facility, QMA 2 text the DON and told her about the incident. QMA 1 was unable to be reached for interview during the survey. Review of a screen shot of the text message sent by QMA 1 to QMA 2, dated 5/4/2025 at 5:09 a.m., indicated QMA 1 pulled Resident B's scheduled "pain pill" but did not administer it			

	because the resident refused to get up. "I have (name of Resident B) pain pill pulled but she is refusing to get up and go to the bathroom so if she don't get up for us I told her I wouldn't give her the pain pill because in all actuality it's a 6 am [sic] med and I don't have to give it cause I leave at that time she the proceeded to tell me she's not going to make deals with her pain medication and I told her whichever she wants to do if she don't wanna get up out the bed and get changed out her wet brief then I will not be giving her that you can give it to her when you have time which will be probably 7-8 am [sic] I'm not sure so I'm leaving it up to her cause I'm not playing her games if she's asleep wants to be lazy and lay in a wet brief and sleep then you can give the medicine when you have time. I'm not gonna argue with her and reward her for being lazy I told her if she's asleep want gets up to let me know by ringing her bell and when she is changed I'll give it then after she gets outta her wet brief I think they need to lower that oxy cause when she's f - - - ked up and high off them she wants to be lazy as f - - k smh [shaking my head]. How do you guys deal with her being lazy like that throughout the day?" Review of time sheets for QMA 1, dated 5/3/25-5/4/25, indicated			

	QMA 1 clocked in on 5/3/2025 at 7:05 p.m. and clocked out on 5/4/2025 at 6:15 a.m. A current undated policy, titled "Abuse, Neglect, and Misappropriation Policy & Procedure" was provided by the Administrator on 6/16/25 at 10:11 a.m. The policy indicated the following: ".... Policy: Dependent Adult Abuse Prevention and Notification All employees of health care facilities are considered "mandatory abuse reporters" under Indiana law. An employee, who, during his or her employment, examines, attend, counsels, or treats a dependent adult and reasonably believes that the adult has suffered adult abuse, mist immediately report the allegations to the Director of Nursing. The Director of Nursing is responsible for immediately reporting allegations of abuse to the Executive Director, or designated facility abuse coordinator. ...." This citation relates to Complaint IN00458918.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the	R 0090	All residents had the potential to be affected by this alleged deficient practice. QMA 1 did not work again after the incident	07/14/2025

	facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:		was reported. No other residents were affected by this alleged deficient practice and all (interview able) residents were surveyed regarding abuse, with no concerns noted. Skin checks were performed on non interview able residents with no concerns noted. Facility leadership and all staff re educated on reportable timelines and protocols. Abuse protocol training will be brought to QAPI as well as monthly staff trainings. ED or designee will perform staff audits weekly for 4 weeks, then monthly for 3 months, to ensure understanding of abuse reporting protocols	

(A) employee's full name; and

(B) dates and hours worked during the past twelve (12) months.

(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.

(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request

Based on interview and record review, the facility failed to ensure an allegation of neglect was reported timely to the State Agency.

Findings include:

Resident B's clinical record was reviewed on 6/16/25 at 10:54 a.m. Diagnoses included adult failure to thrive, hyperlipidemia, narcolepsy, chronic pain, hypertension, asthma, gastro-esophageal reflex disease. psoriatic arthritis, rheumatoid arthritis, overactive bladder, and chronic fatigue.

Medication orders included oxycodone/APAP (opioid

	analgesic) 10-325 scheduled 4 (four) times a day, dated 2/26/25. A facility self-reportable incident, dated 5/5/25, indicated on 5/4/25 at approximately 5:09 a.m., QMA 1 refused to administer a scheduled pain medication to a resident because the resident refused to get up. During an interview on 6/16/25 at 11:16 a.m. QMA 2 indicated on 5/4/25 at approximately 5:09 a.m., QMA 1 sent a text message and indicated they had withheld Resident B's scheduled pain medication because the resident refused to get up. QMA 2 indicated they arrived to the facility around 6:00 a.m. and took report from QMA 1. After QMA 1 left the facility, QMA 2 text the DON and told her about the incident. QMA 2 could not confirm the time a text was sent to the DON. During an interview on 6/16/25 at 1:36 p.m., the DON indicated on 5/4/2025, QMA 2 sent her a text message about the incident. The DON didn't know what time the text was sent but indicated her phone had been charging. The DON confirmed she saw the text from QMA 2 at 9:08 a.m. The DON indicated her phone could have died. The DON believed she text the Administrator on 5/4/25 at 9:26			

	a.m. and was told to make sure QMA 1 was off the schedule and to arrange for QMA 1 to come in for a meeting on the following Monday (5/5/25). During the meeting on 5/5/25 between 3:30 p.m. and 4:00 p.m., QMA 1 told the DON and Administrator she did not know her actions could be considered as abusive. QMA 1 was unable to be reached for interview during the survey. During an interview on 6/16/25 at 2:17 p.m., the Administrator indicated she and the DON discussed the incident on 5/5/25 at approximately 12:43 p.m. The Administrator was unable to remember when the DON had informed her about the incident. The Administrator indicated she reported the incident to the state agency the same day she was informed. Review of a screen shot of the text message sent by QMA 1 to QMA 2, dated 5/4/2025 at 5:09 a.m., indicated QMA 1 pulled Resident B's scheduled "pain pill" but did not administer it because the resident refused to get up. "I have (name of Resident B) pain pill pulled but she is refusing to get up and go to the bathroom so if she don't get up for us I told her I wouldn't give her the pain pill because in all actuality it's a 6 am [sic] med			

	and I don't have to give it cause I leave at that time she the proceeded to tell me she's not going to make deals with her pain medication and I told her whichever she wants to do if she don't wanna get up out the bed and get changed out her wet brief then I will not be giving her that you can give it to her when you have time which will be probably 7-8 am [sic] I'm not sure so I'm leaving it up to her cause I'm not playing her games if she's asleep wants to be lazy and lay in a wet brief and sleep then you can give the medicine when you have time. I'm not gonna argue with her and reward her for being lazy I told her if she's asleep want gets up to let me know by ringing her bell and when she is changed I'll give it then after she gets outta her wet brief I think they need to lower that oxy cause when she's f - - - ked up and high off them she wants to be lazy as f - - k smh [shaking my head]. How do you guys deal with her being lazy like that throughout the day?" Review of time sheets for QMA 1, dated 5/3/25-5/4/25, indicated QMA 1 clocked in on 5/3/2025 at 7:05 p.m. and clocked out on 5/4/2025 at 6:15 a.m. Review of time sheets for QMA 2, for 5/4/2025, indicated QMA 2 clocked in on 5/4/2025 at 5:50 a.m. QMA 2 did not report the			

	incident until after QMA 1 had clocked out at the end of their shift, 6:15 a.m.. Approximately 4 (four) hours had passed from the time of the incident and the time the DON saw the text message from QMA 2. Approximately 28 hours, 10 minutes passed from the time the DON was made aware of the incident and the time the incident was reported to the state agency. A current undated policy, titled "Abuse, Neglect, and Misappropriation Policy & Procedure" was provided by the Administrator on 6/16/25 at 10:11 a.m. The policy indicated the following: ".... Policy: Dependent Adult Abuse Prevention and Notification All employees of health care facilities are considered "mandatory abuse reporters" under Indiana law. An employee, who, during his or her employment, examines, attend, counsels, or treats a dependent adult and reasonably believes that the adult has suffered adult abuse, mist immediately report the allegations to the Director of Nursing. The Director of Nursing is responsible for immediately reporting allegations of abuse to the Executive Director, or designated facility abuse coordinator. ...."			

This citation relates to Complaint IN00458918.

Based on interview and record review, the facility failed to ensure an allegation of neglect was reported timely to the State Agency.

Findings include:

Resident B's clinical record was reviewed on 6/16/25 at 10:54 a.m. Diagnoses included adult failure to thrive, hyperlipidemia, narcolepsy, chronic pain, hypertension, asthma, gastro-esophageal reflex disease. psoriatic arthritis, rheumatoid arthritis, overactive bladder, and chronic fatigue.

Medication orders included oxycodone/APAP (opioid analgesic) 10-325 scheduled 4 (four) times a day, dated 2/26/25.

A facility self-reportable incident, dated 5/5/25, indicated on 5/4/25 at approximately 5:09 a.m., QMA 1 refused to administer a scheduled pain medication to a resident because the resident refused to get up.

During an interview on 6/16/25 at 11:16 a.m. QMA 2 indicated on 5/4/25 at approximately 5:09 a.m., QMA 1 sent a text message and indicated they had withheld Resident B's scheduled pain medication

	because the resident refused to get up. QMA 2 indicated they arrived to the facility around 6:00 a.m. and took report from QMA 1. After QMA 1 left the facility, QMA 2 text the DON and told her about the incident. QMA 2 could not confirm the time a text was sent to the DON. During an interview on 6/16/25 at 1:36 p.m., the DON indicated on 5/4/2025, QMA 2 sent her a text message about the incident. The DON didn't know what time the text was sent but indicated her phone had been charging. The DON confirmed she saw the text from QMA 2 at 9:08 a.m. The DON indicated her phone could have died. The DON believed she text the Administrator on 5/4/25 at 9:26 a.m. and was told to make sure QMA 1 was off the schedule and to arrange for QMA 1 to come in for a meeting on the following Monday (5/5/25). During the meeting on 5/5/25 between 3:30 p.m. and 4:00 p.m., QMA 1 told the DON and Administrator she did not know her actions could be considered as abusive. QMA 1 was unable to be reached for interview during the survey. During an interview on 6/16/25 at 2:17 p.m., the Administrator indicated she and the DON discussed the incident on 5/5/25			

at approximately 12:43 p.m. The Administrator was unable to remember when the DON had informed her about the incident. The Administrator indicated she reported the incident to the state agency the same day she was informed.

Review of a screen shot of the text message sent by QMA 1 to QMA 2, dated 5/4/2025 at 5:09 a.m., indicated QMA 1 pulled Resident B's scheduled "pain pill" but did not administer it because the resident refused to get up. "I have (name of Resident B) pain pill pulled but she is refusing to get up and go to the bathroom so if she don't get up for us I told her I wouldn't give her the pain pill because in all actuality it's a 6 am [sic] med and I don't have to give it cause I leave at that time she the proceeded to tell me she's not going to make deals with her pain medication and I told her whichever she wants to do if she don't wanna get up out the bed and get changed out her wet brief then I will not be giving her that you can give it to her when you have time which will be probably 7-8 am [sic] I'm not sure so I'm leaving it up to her cause I'm not playing her games if she's asleep wants to be lazy and lay in a wet brief and sleep then you can give the medicine when you have time. I'm not gonna argue with her and reward her for being lazy I told

her if she's asleep want gets up to let me know by ringing her bell and when she is changed I'll give it then after she gets outta her wet brief I think they need to lower that oxy cause when she's f - - - ked up and high off them she wants to be lazy as f - - k smh [shaking my head]. How do you guys deal with her being lazy like that throughout the day?"

Review of time sheets for QMA 1, dated 5/3/25-5/4/25, indicated QMA 1 clocked in on 5/3/2025 at 7:05 p.m. and clocked out on 5/4/2025 at 6:15 a.m.

Review of time sheets for QMA 2, for 5/4/2025, indicated QMA 2 clocked in on 5/4/2025 at 5:50 a.m. QMA 2 did not report the incident until after QMA 1 had clocked out at the end of their shift, 6:15 a.m.. Approximately 4 (four) hours had passed from the time of the incident and the time the DON saw the text message from QMA 2. Approximately 28 hours, 10 minutes passed from the time the DON was made aware of the incident and the time the incident was reported to the state agency.

A current undated policy, titled "Abuse, Neglect, and Misappropriation Policy & Procedure" was provided by the Administrator on 6/16/25 at 10:11 a.m. The policy indicated

	the following: ".... Policy: Dependent Adult Abuse Prevention and Notification All employees of health care facilities are considered "mandatory abuse reporters" under Indiana law. An employee, who, during his or her employment, examines, attend, counsels, or treats a dependent adult and reasonably believes that the adult has suffered adult abuse, mist immediately report the allegations to the Director of Nursing. The Director of Nursing is responsible for immediately reporting allegations of abuse to the Executive Director, or designated facility abuse coordinator. ...." This citation relates to Complaint IN00458918.			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person	R 0243	All residents had the potential to be affected by this deficient practice. No other residents were affected by this deficient practice. (interview able) residents were interviewed regarding untimely medication administration with no other concerns noted	07/14/2025

	administering the drug or treatment. Based on record review and interview, the facility failed to ensure the administration of medication was documented accurately by the person who prepared the medication. (Resident B, QMA 1, and QMA 2) Findings include: Resident B's clinical record was reviewed on 6/16/25 at 10:54 a.m. Diagnoses included adult failure to thrive, hyperlipidemia, narcolepsy, chronic pain, hypertension, asthma, gastro-esophageal reflex disease. psoriatic arthritis, rheumatoid arthritis, overactive bladder, and chronic fatigue. The May 2025 Medication Administration Record indicated, on the morning of 5/4/25 at 6:00 a.m., QMA 1 documented they administered Resident B's scheduled oxycodone/APAP (narcotic analgesic) 10-325 mg as ordered at 6:00 a.m. Review of a facility self-reportable incident, dated 5/5/25, indicated on 5/4/25 at approximately 5:09 a.m., QMA 1 refused to administer a scheduled pain medication to Resident B because the resident refused to get up.		Nursing staff educated on proper medication administration and policy DON or designee will audit nursing staff to ensure medication administrations are completed according to policy, weekly for 4 weeks, then monthly for 3 months. Audits will be brought to QAPI	

During an interview on 6/16/2025 at 12:35 p.m., the DON indicated the medication was actually administered by QMA 2 on 5/4/2025 during the morning medication pass.

No policy regarding medication administration was provided by the facility prior to exit.

This citation relates to complaint IN00458918.

Based on record review and interview, the facility failed to ensure the administration of medication was documented accurately by the person who prepared the medication. (Resident B, QMA 1, and QMA 2)

Findings include:

Resident B's clinical record was reviewed on 6/16/25 at 10:54 a.m. Diagnoses included adult failure to thrive, hyperlipidemia, narcolepsy, chronic pain, hypertension, asthma, gastro-esophageal reflex disease. psoriatic arthritis, rheumatoid arthritis, overactive bladder, and chronic fatigue.

	The May 2025 Medication Administration Record indicated, on the morning of 5/4/25 at 6:00 a.m., QMA 1 documented they administered Resident B's scheduled oxycodone/APAP (narcotic analgesic) 10-325 mg as ordered at 6:00 a.m. Review of a facility self-reportable incident, dated 5/5/25, indicated on 5/4/25 at approximately 5:09 a.m., QMA 1 refused to administer a scheduled pain medication to Resident B because the resident refused to get up. During an interview on 6/16/2025 at 12:35 p.m., the DON indicated the medication was actually administered by QMA 2 on 5/4/2025 during the morning medication pass. No policy regarding medication administration was provided by the facility prior to exit. This citation relates to complaint IN00458918.			

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