

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 08/12/2026
NAME OF PROVIDER OR SUPPLIER HERITAGE ASSISTED LIVING OF UNION CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 204 STAUDT DRIVE, UNION CITY, , 47390			
(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 Intake 470346. Intake 470346 - State deficiencies related to the allegations are cited at R0190. Survey dates: August 11 and 12, 2026 Facility number: 015887 Residential Census: 46 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 20, 2026.	R 0000			
R 0190	Physical Plant Standards - Noncompliance 410 IAC 16.2-5-1.6(n)(1-5) (n) The facility shall have living areas with sufficient space to accommodate the dining, activity,	R 0190	We will be installing an ADA compliant ramp for all patio doors.	08/25/2026	

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and lounge needs of the residents and to prevent the interference of one (1) function with another as follows: (1) Dining, lounge, and activity areas shall be: (A) readily accessible to wheelchair and ambulatory residents; and (B) sufficient in size to accommodate necessary equipment and to permit unobstructed movement of wheelchairs, residents, and personnel responsible for assisting, instructing, or supervising residents. (2) Dining tables of the appropriate height shall be provided to assure access to meals and comfort for residents seated in wheelchairs, geriatric chairs, and regular dining chairs. (3) A comfortably furnished resident living and lounge area shall be provided on each resident occupied floor of a multi-story building. This lounge may be furnished and maintained to accommodate activity and dining functions. (4) An area for resident activities. In a facility for which plans were approved after December 19, 1977, a restroom large enough to accommodate a wheelchair and equipped with grab bars located near the activity room shall be provided. (5) For facilities and additions to facilities for which construction	The facility will identify this correction by installing in all resident rooms with patios. Preventative measures will be to install ADA compliant ramps in all rooms with patios. This will be monitored through monthly inspections for six months to make sure there isn't any damage by Maintenance. Occupied rooms will be completed within 30 days. Unoccupied rooms will be completed prior to new rentals.	
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plans are submitted for approval after July 1, 1984, the total area for resident dining, activities, and lounge purposes shall not be less than thirty (30) square feet per bed.

Based on observation, interview, and record review, the facility failed to ensure residents' patio lounge spaces were wheelchair accessible for residents in wheelchairs and residents with mobility assistive devices for 2 of 3 residents reviewed for environment.

(Resident B and Resident C)
This deficiency had the potential to affect 5 residents with mobility adaptive devices (3 wheelchairs and 2 walkers) out of 15 residents who had rooms with patio access.

Findings include:

1. During an observation on 8/11/26 at 11:48 a.m., Resident B propelled in his wheelchair to the dining room table in the main dining room.

During an observation on 8/11/26 at 1:17 p.m., Resident B was in his room seated in his wheelchair with oxygen on via nasal cannula. The threshold between his room and his patio was raised approximately one inch from the flooring on the inside of the patio door. Due to it being raised, one had to step over the threshold to go onto the patio. From the outside, the

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OMB NO. 0938-0391

threshold was raised approximately 0.75 inch from the concrete patio. Each side had a sudden change in height and was not wheelchair accessible. During an interview at the time of the observation, Resident B indicated he used the manual wheelchair for mobility. He had an electric scooter, but was not comfortable to use it. He was not able to get in and out of his patio with his wheelchair because it did not have a ramp to get over the threshold. He would like to go out on his patio, but he did not want to fall. Since he did not think it was safe, he just sat in his room and looked out the door at the chairs on his patio. He had a previous fall when he was in independent living and he did not want to fall again. Resident B did not ask staff to assist him out to the patio because they were busy.

Resident B's clinical record was reviewed on 8/11/26 at 3:19 p.m. Diagnoses included pneumonia.

A 7/7/26, Service Plan indicated the resident was independent with daily decision making. He used a wheelchair and a scooter for mobility.

A 7/7/26, initial evaluation indicated the resident was at moderate risk for falls.

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2. During an observation on 8/11/26 at 12:05 p.m., Resident C was seated in her wheelchair at the dining room table in the main dining room eating lunch.

During an observation on 8/11/26 at 1:41 p.m., Resident C was in her room seated in her wheelchair. The threshold between her room and her patio was raised approximately 1 inch from the flooring on the inside of the patio door. Due to it being raised, one had to step over the threshold to go onto the patio. From the outside, the threshold was raised approximately 0.75 inch from the concrete patio. Each side had a sudden change in height and was not wheelchair accessible. During interview, Resident C indicated she was not able to get out onto her patio because the threshold was too big. Her daughter had taken her out there a few times to visit with the grandchildren. She would like to have the wheelchair accessibility to ambulate out onto her patio in her wheelchair when she wanted to go out there. Since it was not wheelchair accessible, she sometimes sat in her room, at the patio door, and left the door open while she looked out.

Resident C's clinical records was reviewed on 8/11/26 at 3:54 p.m. Diagnosis included diabetes mellitus due to

underlying condition with diabetic neuropathy, other abnormalities of gait and mobility, and history of falling.

A 5/15/26, Service Plan indicated the resident was a risk for falls. Interventions included the resident would remain free from serious injuries from falls. The resident required a wheelchair for mobility assistance due to weakness and one staff assistance for transfers.

A 5/15/26, quarterly evaluation indicated the resident was at high risk for falls.

During an interview on 8/11/26 at 2:16 p.m., the DON indicated a new resident who used a wheelchair wanted to sit on his patio on 8/10/26. A staff member assisted the resident over the threshold to get out on his patio and assisted him back in when he was finished. She was unaware of any reported concerns with the raised thresholds. There were three residents who resided in rooms with a patio that required wheelchairs for mobility. There were two residents who resided in rooms with a patio that required walkers for mobility. The raised thresholds were a potential fall hazard related to potential tipping of the wheelchair. It also caused potential difficulties for residents

with walkers to access their patios. All of the rooms with patios had the same raised threshold without a gradual incline.

On 8/11/26 at 2:33 p.m., the Maintenance Director indicated no one had notified him of any concerns about the raised thresholds between resident rooms and the patio. He could understand why wheelchairs and walkers would have difficulty getting over it since it did not have a gradual incline on either side. He knew it was difficult to get the wheels of a knee scooter over it without picking up the knee scooter and lifting it over the threshold. It was a potential fall hazard.

During an observation on 8/11/26 at 2:42 p.m., the Maintenance Director measured the raised threshold in Resident C's room. On the inside, the threshold measured 1.5 inches from the flooring in the resident's room. On the outside, the threshold measured 0.5 inch to 0.75 inch from the concrete patio. Neither side had a ramp to get over the threshold. He indicated all of the resident rooms with patios had the same raised threshold. This happened when the facility was remodeled. They did not install the plates/ramps on each side of the threshold to make them a

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gradual transition for wheelchairs.

During an interview on 8/12/26 at 11:32 a.m., the Administrator indicated the residents should have the accessibility to safely go in and out of their patio when they want to use their patio. This also applied to residents who required mobility assistive devices.

On 8/12/26 at 11:50 p.m., the Administrator indicated the facility did not have a policy regarding wheelchair accessibility for residents.

This citation relates to Intake 470346.

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
SIGNATURENicole Fenton

TITLEExecutive Director

(X6) DATE09/02/2026