

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 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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00453440. Complaint IN00453440 - No deficiencies related to the allegations are cited. Survey dates: March 11 and 12, 2025 Facility number: 015887 Residential Census: 22 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 19, 2025.	R 0000					
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training	R 0117	R0117 The one staff member (Ashlyn Graham) was certified with a letter to confirm that the course was completed successfully. (see			04/18/2025	

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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 assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.

Based on interview and record review, the facility failed to ensure each shift was staffed with at least one staff member certified in First Aid. This deficient practice had the potential to affect 22 of 22 residents who resided in the facility.

Findings include:

Review of the employee

attachment#1)

All 22 residents had a potential of being affected.

The current Director of Nursing is now certified to teach all CPR and First Aid classes (see attachment#2)

All nursing staff are now certified in CPR and First Aid.

CPR and First Aid binder will be reviewed during QA meeting on a monthly basis to assure substantial compliance

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schedule from 3/6/25 to 3/12/25 lacked a staff member on duty with a First Aid certification for 7 of 21 shifts reviewed. The dates and shifts were as follows:

- a. 3/6/25- third shift
- b. 3/7/25- third shift
- c. 3/8/25- third shift
- d. 3/9/25- third shift
- e. 3/10/25- third shift
- f. 3/11/25- third shift
- g. 3/12/25- third shift

During an interview on 3/12/25 at 12:40 p.m., the Administrator indicated she was not aware the facility lacked a First Aid certified staff member on the 6:00 p.m. to 6:00 a.m. shift from 3/6/25 through 3/12/25. She thought LPN 5 was certified in First Aid. She planned to look again for LPN5's First Aid certification.

No further information regarding First Aid certification for LPN 5 was provided prior to exit.

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During an interview on 3/12/25 at 1:39 p.m., the DON indicated she was unaware a First Aid certified staff member was required to be present in the facility when the DON was on call and lived close to the facility.

During an interview on 3/12/25 at 3:09 p.m., the Administrator indicated the facility lacked a policy regarding First Aid certified staff.

Based on interview and record review, the facility failed to ensure each shift was staffed with at least one staff member certified in First Aid. This deficient practice had the potential to affect 22 of 22 residents who resided in the facility.

Findings include:

Review of the employee schedule from 3/6/25 to 3/12/25 lacked a staff member on duty with a First Aid certification for 7 of 21 shifts reviewed. The dates and shifts were as follows:

- a. 3/6/25- third shift
- b. 3/7/25- third shift
- c. 3/8/25- third shift
- d. 3/9/25- third shift
- e. 3/10/25- third shift

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	f. 3/11/25- third shift g. 3/12/25- third shift During an interview on 3/12/25 at 12:40 p.m., the Administrator indicated she was not aware the facility lacked a First Aid certified staff member on the 6:00 p.m. to 6:00 a.m. shift from 3/6/25 through 3/12/25. She thought LPN 5 was certified in First Aid. She planned to look again for LPN5's First Aid certification. No further information regarding First Aid certification for LPN 5 was provided prior to exit. During an interview on 3/12/25 at 1:39 p.m., the DON indicated she was unaware a First Aid certified staff member was required to be present in the facility when the DON was on call and lived close to the facility. During an interview on 3/12/25 at 3:09 p.m., the Administrator indicated the facility lacked a policy regarding First Aid certified staff.			
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	R 0217	1. Service plans will be signed immediately after assessment input and service plan is generated resident or family will sign a copy and or electronically sign then will be in resident's file. 2. No residents were affected by	03/12/2025

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document the services to be provided by the facility, as follows: (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		alleged deficient practice. R0217 Resident service plans for 9,11,26 were reviewed and signed by the resident by 4.15.25. R0217 All service plans were reviewed and assured all service plans were signed. R0217 Service plans will be signed immediately by resident and or POA (if appropriate). R0217 Binder was completed on 4.1.25 completed for all residents and will be reviewed at monthly QA meeting until substantial compliance is completed and will review for all residents for three months.	
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review, the facility failed to ensure service plans were signed by a resident and/or their representative for 3 of 7 clinical records reviewed. (Residents 9, 11, and 26)

Findings include:

1. Resident 9's clinical record was reviewed on 3/11/25 at 3:09 p.m. Diagnosis included hypertension.

Review of the resident's current service plan, dated 11/6/24, lacked a resident or resident representative signature for acknowledgement of the services needed by the resident. The service plan was signed only by the facility staff.

During an interview on 3/12/25 at 11:39 a.m., the DON indicated Resident 9's clinical record lacked a service plan signed by the resident or resident representative.

2. Resident 11's clinical record was reviewed on 3/11/25 at 2:06 p.m. Diagnoses included dementia and Parkinson's disease without dyskinesia.

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Review of the resident's current service plan, dated 2/18/25, lacked a resident or resident representative signature for acknowledgement of the services needed by the resident. The service plan was signed only by the facility staff.

3. Resident 26's clinical record was reviewed on 3/12/25 at 9:40 a.m. Diagnoses included dementia, type 2 diabetes mellitus, and chronic obstructive pulmonary disease.

Review of the resident's current service plan, dated 11/6/24, lacked a resident or resident representative signature for acknowledgement of the services needed by the resident. The service plan was signed only by the facility staff.

During an interview on 3/12/25 at 11:59 a.m., the DON indicated Resident 26's clinical record lacked a service plan signed by the resident or resident representative.

Review of a current, undated, facility policy, titled "Assistance/Service Plan," provided by the DON on 3/12/25 at 2:04 p.m., indicated the following: "Procedure: ...2. The Resident Assistant and Resident Services Coordinator will visit with the resident and family to develop the plan... 4. All components of the

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assistance/service plan form must be completed...."

Based on interview and record review, the facility failed to ensure service plans were signed by a resident and/or their representative for 3 of 7 clinical records reviewed. (Residents 9, 11, and 26)

Findings include:

1. Resident 9's clinical record was reviewed on 3/11/25 at 3:09 p.m. Diagnosis included hypertension.

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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' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to prevent the utilization of unpasteurized eggs for the preparation of soft-cooked eggs for the residents. This deficiency had the potential to affect 22 of 22 residents who received meals from the facility kitchen. Findings include: During a tour of the kitchen, on 3/11/25 at 10:27 a.m., raw, whole, unpasteurized eggs were observed in the walk-in refrigerator. There were also cartons of pasteurized liquid egg substitute in the refrigerator. During an interview at the time of observation on 3/11/25 at 10:34 a.m., Cook 4 indicated the raw whole unpasteurized eggs in the walk-in refrigerator were the eggs utilized during preparation of eggs for all of the residents every day for breakfast. She prepared the eggs according to the residents' preferences which included	R 0273	1 As of 3/12/2025 all unpasteurized eggs were removed from the facility. Dietary vendor was contacted to confirm delivery of pasteurized eggs. Dietary substitutions were made available until pasteurized eggs were delivered. 2 Dietary Director will monitor alleged deficient practice by monitoring dietary deliveries weekly. 3 Dietary was in serviced on not using unpasteurized eggs and to make substitutions using pasteurized liquid eggs. 4. Dietary Director will monitor alleged deficient practice by monitoring dietary deliveries weekly and make substitutions as needed.	03/12/2025
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scrambled, hard cooked, and over-easy. All of the residents notified the cook how they wanted their eggs prepared each day. Two residents always requested their eggs over-easy every day for breakfast. A few other residents occasionally requested their eggs over-easy. She last prepared eggs over-easy for two residents on 3/11/25. She had never seen any raw whole pasteurized eggs available for use since she had been in her position. She was uncertain if pasteurized eggs were required when she prepared eggs over-easy.

During an interview on 3/12/25 at 12:40 p.m., the Dietary Manager (DM) indicated he ordered the food supplies for the kitchen food preparation. He typically ordered the cartoned pasteurized eggs for scrambled eggs. He ordered the 15 dozen carton of raw whole eggs that were unpasteurized because their approved vendor had the pasteurized eggs marked as unavailable. He had not reached out to any other vendors to purchase pasteurized eggs. He was aware some of the residents continued to have their eggs prepared over easy.

During an interview on 3/12/25 at 1:00 p.m., the Administrator indicated the DM had not made her aware he was unable to

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purchase pasteurized eggs from the facility approved vendor when he placed his orders.

During an interview on 3/12/25 at 1:25 p.m., the Administrator indicated the facility lacked a policy regarding the use of pasteurized eggs to prevent foodborne illnesses.

During an interview on 3/12/25 at 2:28 p.m. the Administrator provided a breakfast menu and indicated all of the items were available every day for all of the residents. The menu included eggs: scrambled, hard, or easy.

According to the United States Department of Agriculture (USDA) website page "Shell Eggs from Farm to Table," <https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/eggs/shell-eggs-farm-to-table#6>, retrieved on 3/13/25 at 8:35 a.m., indicated " ...To be safe, eggs must be safely handled, promptly refrigerated, and thoroughly cooked ...It is also possible for eggs to become infected by Salmonella Enteritidis (SE) fecal contamination through the pores of the shells after they're laid. SE can also be inside an uncracked whole egg ...everyone is advised against eating raw or undercooked egg yolks and whites ...Infants, young children, older adults, pregnant women, and people

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with weakened immune systems are particularly vulnerable to SE infections. A chronic illness weakens the immune system, making the person vulnerable to foodborne illnesses"

Based on observation, interview, and record review, the facility failed to prevent the utilization of unpasteurized eggs for the preparation of soft-cooked eggs for the residents. This deficiency had the potential to affect 22 of 22 residents who received meals from the facility kitchen.

Findings include:

During a tour of the kitchen, on 3/11/25 at 10:27 a.m., raw, whole, unpasteurized eggs were observed in the walk-in refrigerator. There were also cartons of pasteurized liquid egg substitute in the refrigerator.

During an interview at the time of observation on 3/11/25 at 10:34 a.m., Cook 4 indicated the raw whole unpasteurized eggs in the walk-in refrigerator were the eggs utilized during preparation of eggs for all of the residents every day for breakfast. She prepared the eggs according to the residents' preferences which included scrambled, hard cooked, and over-easy. All of the residents notified the cook how they wanted their eggs prepared

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each day. Two residents always requested their eggs over-easy every day for breakfast. A few other residents occasionally requested their eggs over-easy. She last prepared eggs over-easy for two residents on 3/11/25. She had never seen any raw whole pasteurized eggs available for use since she had been in her position. She was uncertain if pasteurized eggs were required when she prepared eggs over-easy.

During an interview on 3/12/25 at 12:40 p.m., the Dietary Manager (DM) indicated he ordered the food supplies for the kitchen food preparation. He typically ordered the cartoned pasteurized eggs for scrambled eggs. He ordered the 15 dozen carton of raw whole eggs that were unpasteurized because their approved vendor had the pasteurized eggs marked as unavailable. He had not reached out to any other vendors to purchase pasteurized eggs. He was aware some of the residents continued to have their eggs prepared over easy.

During an interview on 3/12/25 at 1:00 p.m., the Administrator indicated the DM had not made her aware he was unable to purchase pasteurized eggs from the facility approved vendor when he placed his orders.

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	making the person vulnerable to foodborne illnesses"			
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 record review and interview, the facility failed to ensure admission tuberculin (TB) skin tests were completed for 2 of 7 residents reviewed for TB testing. (Residents 26 and 5)	R 0410	1.All new admissions will receive a PPD on admission and or 30 days prior to admission. 2.No residents were affected by the alleged deficient practices. 3. Residents # 26 and #5 given PPD 4.28.25. All residents were reviewed, and binder has been completed for all residents with completion dates and no other residents were found out of compliance. All new admissions will be added to the binder and will be reviewed monthly at the QA meeting to review substantial compliance.	03/12/2025

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Findings include:

1. Resident 26's clinical record was reviewed on 3/12/25 at 9:40 a.m. The resident admitted to the facility on 4/19/24. Diagnoses included, dementia and Parkinson's disease.

During an interview on 3/12/25 at 11:59 a.m., the DON indicated the resident's clinical record lacked a first and second step preadmission/admission tuberculin test with a reading.

2. Resident 5's clinical record was reviewed on 3/12/25 at 10:24 a.m. The resident admitted to the facility on 11/2/24. Diagnoses included, chronic atrial fibrillation, bipolar disorder, and depression.

A one-step negative Mantoux (TB skin test) had been read on 3/17/24 at 7:38 p.m. from a previous facility document.

During an interview on 3/12/25 at 1:39 p.m., the DON indicated the resident's clinical record lacked any additional preadmission/admission tuberculin test with a reading.

A current facility policy, undated, titled "Testing," provided by the DON on 3/12/25 at 2:04 p.m., indicated the following:
"Procedure: 1. All residents will be given a 2-step Mantoux test per guidelines within 3 days of entering the residence. If a test

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has been completed within 3 months of admission to the residence and copies of the test results are available, there is no need to repeat the test...."

Based on record review and interview, the facility failed to ensure admission tuberculin (TB) skin tests were completed for 2 of 7 residents reviewed for TB testing. (Residents 26 and 5)

Findings include:

1. Resident 26's clinical record was reviewed on 3/12/25 at 9:40 a.m. The resident admitted to the facility on 4/19/24. Diagnoses included, dementia and Parkinson's disease.

During an interview on 3/12/25 at 11:59 a.m., the DON indicated the resident's clinical record lacked a first and second step preadmission/admission tuberculin test with a reading.

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"Procedure: 1. All residents will be given a 2-step Mantoux test per guidelines within 3 days of entering the residence. If a test has been completed within 3 months of admission to the residence and copies of the test results are available, there is no need to repeat the test...."

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