STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING OF UNION CITY	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. Survey dates: December 29 and 30, 2025 Facility number: 015887 Residential Census: 34 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 6, 2025.	R 0000		
R 0048	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(r)(18-24) (18) Prior to any interfacility or involuntary intrafacility relocation, the facility shall prepare a relocation plan to prepare the resident for relocation and to provide continuity of care. In nonemergency relocations, the planning process shall include a relocation planning conference to	R 0048	POC -Transfer form will print automatically w/ packet upon transfer. Form will be completed by on duty staff and submitted. All nursing staff educated on new process. Date implemented: 1/13/26	01/09/2026

which the resident, his or her legal representative, family members, and physician shall be invited. The planning conference may be waived by the resident.

(19) At the planning conference the resident ' s medical, psychosocial, and social needs with respect to the relocation shall be considered and a plan devised to meet these needs.

(20) The facility shall provide reasonable assistance to the resident to carry out the relocation plan.

(21) The facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(22) If the relocation plan is disputed, a meeting shall be held prior to the relocation with the administrator or his or her designee, the resident, and the resident ' s legal representative. An interested family member, if known, shall be invited. The purpose of the meeting shall be to discuss possible alternatives to the proposed relocation plan.

(23) A written report of the content of the discussion at the meeting and the results of the meeting shall be reviewed by:

(A) the administrator or his or her designee;

(B) the resident;

(C) the resident ' s legal representative; and

(D) an interested family member, if known; each of whom may make written comments on the report.

(24) The written report of the meeting shall be included in the resident ' s permanent record.

Based on interview and record review, the facility failed to notify the long-term care Ombudsman regarding a resident transfer/discharge for 1 of 2 residents reviewed for transfer/discharge. (Resident 38)

Finding includes:

Resident 38's record was reviewed on 12/30/25 at 10:02 a.m. Diagnoses included dementia, depressive disorder, and type 2 diabetes.

A 9/11/25, nurse's note indicated the resident was sent out to the hospital following a fall.

A 9/13/25, nurse's note indicated the resident was sent to a rehabilitation facility from the hospital.

The clinical record lacked ombudsman notification of the transfer.

During an interview, on 12/30/25 at 1:49 p.m., the Administrator indicated she was unaware the ombudsman needed to be

notified if a resident was sent out emergently.

A current facility policy, revised 11/2025 and titled "Transfer Out Policy", provided by the DON on 12/30/25 at 3:51 p.m., included the following: "Purpose: To ensure resident receive appropriate care and support when of a transfer out of the community is necessary due to physical cognitive, or emergency needs ...."

Based on interview and record review, the facility failed to notify the long-term care Ombudsman regarding a resident transfer/discharge for 1 of 2 residents reviewed for transfer/discharge. (Resident 38)

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	transfer. During an interview, on 12/30/25 at 1:49 p.m., the Administrator indicated she was unaware the ombudsman needed to be notified if a resident was sent out emergently. A current facility policy, revised 11/2025 and titled "Transfer Out Policy", provided by the DON on 12/30/25 at 3:51 p.m., included the following: "Purpose: To ensure resident receive appropriate care and support when of a transfer out of the community is necessary due to physical cognitive, or emergency needs ...."			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training 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	R 0117	POC: Schedule will be posted and names highlighted if CPR needed all other staff with certification will be renewed on their renewal date. Any current staff without CPR/First Aid Trg will be notified of upcoming classes to attend. All shifts will be covered with certified individuals of CPR/First Aid. We are allotted time off to complete CPR/First Aid course as needed. Date Implemented: 1/1/26.	01/09/2026

	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 had at least one staff member certified in cardiopulmonary resuscitation (CPR) and First Aid. This deficient practice had the potential to affect 34 of 34 residents who resided in the facility. Findings include: 1. Review of the employee schedule from 12/19/25 to 12/25/25 indicated the facility lacked a staff member on duty with a CPR certification for 5 out of 21 shifts reviewed on the following dates: 12/19/25 - second shift 12/22/25 - third shift 12/23/25 - third shift 12/24/25 - second shift			

12/25/25 - second shift

2. Review of the employee schedule from 12/19/25 to 12/25/25 lacked a staff member on duty with a First Aid certification for 12 of 21 shifts reviewed on the following dates:

12/19/25- first and second shifts

12/22/25- first, second, and third shifts

12/23/25- first, second, and third shifts

12/24/25- first and second shifts

12/25/25- first and second shifts

During an interview on 12/30/25 at 12:53 p.m., the Administrator indicated the facility should have staff on duty 24 hours that were certified in First Aid and CPR.

During an interview on 12/30/25 at 4:50 p.m., the DON indicated she was not able to provide any further certifications for CPR or First Aid for the staff members on duty for the above mentioned shifts the week of 12/19/25 through 12/25/25.

A current, undated, facility policy titled "Emergency Care," provided by the Administrator on 12/30/25 at 4:20 p.m., indicated the following: "Purpose: To assure adequate response to resident emergencies. Policy Statement: Residents will

	receive appropriate emergency care ... Staff will be trained in first aid and CPR for early management of problems. When in doubt, the emergency medical services system will be activated ...." Based on interview and record review, the facility failed to ensure each shift had at least one staff member certified in cardiopulmonary resuscitation (CPR) and First Aid. This deficient practice had the potential to affect 34 of 34 residents who resided in the facility. Findings include: 1. Review of the employee schedule from 12/19/25 to 12/25/25 indicated the facility lacked a staff member on duty with a CPR certification for 5 out of 21 shifts reviewed on the following dates: 12/19/25 - second shift 12/22/25 - third shift 12/23/25 - third shift 12/24/25 - second shift 12/25/25 - second shift 2. Review of the employee schedule from 12/19/25 to 12/25/25 lacked a staff member on duty with a First Aid certification for 12 of 21 shifts			

	reviewed on the following dates: 12/19/25- first and second shifts 12/22/25- first, second, and third shifts 12/23/25- first, second, and third shifts 12/24/25- first and second shifts 12/25/25- first and second shifts During an interview on 12/30/25 at 12:53 p.m., the Administrator indicated the facility should have staff on duty 24 hours that were certified in First Aid and CPR. During an interview on 12/30/25 at 4:50 p.m., the DON indicated she was not able to provide any further certifications for CPR or First Aid for the staff members on duty for the above mentioned shifts the week of 12/19/25 through 12/25/25.			

	A current, undated, facility policy titled "Emergency Care," provided by the Administrator on 12/30/25 at 4:20 p.m., indicated the following: "Purpose: To assure adequate response to resident emergencies. Policy Statement: Residents will receive appropriate emergency care ... Staff will be trained in first aid and CPR for early management of problems. When in doubt, the emergency medical services system will be activated ...."			
R 0383	Mental Health Screening - Deficiency 410 IAC 16.2-5-11.1(g)(1-2) (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more	R 0383	POC: Resident 13 has now been referred to as outpatient psych services with Meridian Health in Winchester, Indiana. Family was notified by Meridian to set an apt time for initial assessment. Family will notify facility w/ day of appointment. Assessed on 1/5/26 by in house NP. Order was sent to Meridian Health on 1/12/26.	01/09/2026

	independent living arrangements. Based on interview and record review, the facility failed to provide psychiatric services and include the psychiatric provider in the creation of a comprehensive care plan for a resident with a major mental illness. (Resident 13) Finding includes: Resident 13's record was reviewed on 12/29/25 at 1:52 p.m. Diagnoses included bipolar disorder, dementia, and chronic kidney disease. A Brief Interview for Mental Status (BIMs) completed on 3/31/25 indicated the resident was severely cognitively impaired. A 4/4/25, current service plan indicated the resident required frequent help due to disorientation, memory loss, and difficulty completing tasks. Resident 13 was disorientated to person/time/place and had a memory or cognitive impairment, per her physician. The service plan lacked inclusion of psychiatric services. A 12/30/25 interview with the DON indicated the current physician service line used by the facility did not include psychiatric services for residents. Resident 13 was not			

receiving psychiatric services and psychiatry was not involved in the creation of her service plan. A psychiatric services policy was requested during this interview.

No further information was provided prior to exit on 12/30/25 at 5:30 p.m.

Based on interview and record review, the facility failed to provide psychiatric services and include the psychiatric provider in the creation of a comprehensive care plan for a resident with a major mental illness. (Resident 13)

Finding includes:

Resident 13's record was reviewed on 12/29/25 at 1:52 p.m. Diagnoses included bipolar disorder, dementia, and chronic kidney disease.

A Brief Interview for Mental Status (BIMs) completed on 3/31/25 indicated the resident was severely cognitively impaired.

A 4/4/25, current service plan indicated the resident required frequent help due to disorientation, memory loss, and difficulty completing tasks. Resident 13 was disorientated to person/time/place and had a memory or cognitive impairment, per her physician. The service plan lacked

	inclusion of psychiatric services. A 12/30/25 interview with the DON indicated the current physician service line used by the facility did not include psychiatric services for residents. Resident 13 was not receiving psychiatric services and psychiatry was not involved in the creation of her service plan. A psychiatric services policy was requested during this interview. No further information was provided prior to exit on 12/30/25 at 5:30 p.m.			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to verify by statement annually that residents were free from infectious tuberculosis for 3 of 7 residents reviewed for annual health statements. (Resident 35, Resident 17, and Resident 10)	R 0409	POC: The annual TB questionnaire has been updated to include "free of communicable diseases" and they will be signed by professional (MD, DO, NP, etc.) Form was update during survey implemented immediately. 12/30/25.	01/09/2026

Findings include:

Resident 35's clinical record was reviewed on 12/30/25 at 8:30 a.m. and lacked an annual health statement.

Resident 17's clinical record was reviewed on 12/30/25 at 10:30 a.m. and lacked an annual health statement.

Resident 10's clinical record was reviewed on 12/30/25 at 12:01 p.m. and lacked an annual health statement.

During an interview on 12/30/25 at 12:35 p.m., the DON indicated she was unable to provide annual health statements for Resident 35, Resident 17, and Resident 10. For some reason, the corporation had created a new form and left the annual health statement and provider signature off of the form.

During an interview on 12/30/25 at 2:52 p.m., the DON indicated she was unable to provide a policy on the annual health statements. They followed the Indiana Department of Health guidelines regarding annual health statements.

Based on record review and interview, the facility failed to verify by statement annually that residents were free from infectious tuberculosis for 3 of 7 residents reviewed for annual

health statements. (Resident 35, Resident 17, and Resident 10)

Findings include:

Resident 35's clinical record was reviewed on 12/30/25 at 8:30 a.m. and lacked an annual health statement.

Resident 17's clinical record was reviewed on 12/30/25 at 10:30 a.m. and lacked an annual health statement.

Resident 10's clinical record was reviewed on 12/30/25 at 12:01 p.m. and lacked an annual health statement.

During an interview on 12/30/25 at 12:35 p.m., the DON indicated she was unable to provide annual health statements for Resident 35, Resident 17, and Resident 10. For some reason, the corporation had created a new form and left the annual health statement and provider signature off of the form.

During an interview on 12/30/25 at 2:52 p.m., the DON indicated she was unable to provide a policy on the annual health statements. They followed the Indiana Department of Health guidelines regarding annual health statements.

instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURENicole Fenton	TITLEExecutive Director	(X6) DATE01/20/2026