STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/07/2023

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VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00421885 and IN00421604. Complaint IN00421885 - No deficiencies related to the allegation are cited. Complaint IN00421604 - No deficiencies related to the allegation are cited. Survey dates: December 6 and 7, 2023. Facility number: 015081 Residential Census: 74 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed December 15, 2023.	R 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the plan of correction be considered the letter of credible allegation of compliance and request for a desk review (compliance) by 01/26/2024.	
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and interview, the facility failed to have the most recent State Survey results readily available to the public. Finding includes: During an observation of the facility's main floor common areas on 12/6/23 at 12:36 p.m., the Indiana	R 0042	It is the intent of Vita of Marion to provide access to the facility's State Survey results as required by 410 IAC 16.2-5-1.2(p). The deficiency had the potential to affect all residents. ED investigated ledge where survey results are kept and found that	01/26/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	State Survey Reports were not found to be available. There was no signage to indicate where they could be located. During an interview, on 12/7/23 at 11:59 a.m., the Receptionist indicated the Indiana State Survey Results binder was usually kept on the front desk ledge. She located the survey binder under another binder and several papers on her desk. During an interview, on 12/7/23 at 3:34 p.m., the Administrator indicated the most current survey results were not in the Indiana State Survey Results binder. The binder should be kept on the front desk. He had placed a sign indicating the survey results were located on the front desk. He was uncertain if the sign was located there now.		signage indicating survey results are available there had been removed. A review was completed on the survey book to be sure it was updated and contained all appropriate survey results on 12/28/2023. New sign was made and hung on wall indicating location of the Survey Book, by the ED on 12/29/2023. To ensure ongoing compliance the ED/Designee will check that State Survey Book is accessible and signage is present and visible. Any issues will be addressed immediately. Findings will be reported to the Quality Assurance Committee. Date of compliance: 01/26/2024	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded			

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	announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure fire drills were conducted. This deficient practice had the potential to affect 74 of 74 residents residing in the facility. Findings include: A review of facility fire drill records, provided on 12/7/23 at 10:35 p.m. by the Administrator, indicated lack of fire drills performed before June 2023 and after September 2023. During an interview, on 12/7/23 at 11:48 a.m., the Maintenance Manager indicated they use an electronic system which notifies them quarterly when fire drills are due. Fire drills were performed between June 2023 to September 2023 on every shift. A current, undated facility policy, provided by the Administrator on 12/7/23 at 8:10 p.m., titled "Fire" indicated "...fire drills will occur on a monthly basis ...."	R 0092	It is the intent of Vita of Marion to conduct fire drills as required by 410 IAC 16.2-5-1.3. This deficiency had the potential to affect all residents. The deficiency was corrected upon identification. The community utilizes TELS for documentation of fire drills. As a preventive measure, maintenance staff will be re-educated on Fire Drill Policy & Procedure by 01/26/2024/14/23. To prevent reoccurrence, the Maintenance Director/Designee will audit fire drills as they occur to ensure compliance. Any findings will be reported to the Quality Assurance Committee. Date of compliance: 01/26/2024	01/26/2024
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references			

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	and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to ensure reference checks were completed for employees prior to employment (LPN 4). Findings include: Employee records were provided by the administrator and reviewed on 12/7/23 at 10:00 a.m. A review of LPN 4's record indicated her start date was 2/6/23. Her records lacked indication of reference checks being completed. During an interview, on 12/7/23 at 1:25 p.m., the DON indicated they would look for LPN 4's references. No further information was provided by the facility prior to completion of survey activities.	R 0116	It is the intent of Vita of Marion that perspective employees have the proper pre-employment screenings to work in our facilities as required by 410 IAC 16.2-5-1.4(a). The deficiency had the potential to affect all residents. All current employee files were audited on 12/28/2023 by the administrative assistant to ensure they were compliant with PLC policy. All files that were found to be out of compliance will be updated by 01/26/2024. All future employees will be onboarded according to PLC policy and will have the required preemployment references checked by the facility management team. The facility will review all required documentation and ensure all new employees have been properly onboarded before working at the facility. A review of the pre-employment policy will be conducted with department heads by 01/26/2024 by ED/Designee. All required procedures in the policy will be followed by facility going forward and no future employees will be allowed to work without required documentation. All pre-employment documentation will be reviewed prior to any new employees working on the floor to ensure that	01/26/2024

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			all required processes and policies are followed related to the hiring policy. This will be initiated and conducted by the ED/Designee and will be ongoing. A QAPI plan has been initiated and will be followed/reviewed and revised in the monthly QA meeting. Date of compliance: 01/26/2024 -	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (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 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 record review and interview, the facility	R 0117	It is the intent of Vita of Marion	01/26/2024

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	failed to ensure a first aid trained staff member was scheduled onsite for 3 of 21 shifts reviewed, and a staff member trained in cardiopulmonary resuscitation (CPR) was scheduled onsite for 3 of 21 shifts reviewed. A record review, on 12/7/23 at 2:33 p.m., of the employee first aid and CPR certifications, provided by the DON on 12/7/23 at 2:16 p.m., and the facility employee schedule provided by DON on 12/6/23 at 11:00 a.m., indicated the following: No staff member trained in first aid was scheduled night shift on 12/4/23 and 12/5/23 nor on second shift for 12/5/23. No staff member certified in CPR was scheduled on night shift on 12/4/23 and 12/5/23 nor on second shift for 12/5/23. During an interview, on 12/7/23 at 3:35 p.m., the DON indicated she was unable to locate additional employee first aid and CPR certifications for employees scheduled on 12/4/23 and 12/5/23.		that perspective employees have the proper pre-employment licenses and certificates to work in our facility as required by 410 IAC 16.2-5-1.4(b). The deficiency had the potential to affect all residents. All current nursing employee files will be audited by 01/26/2024 by the DON/Designee to ensure they are certified in both CPR and Basic First Aid. All employees that are found to not be certified will be required to be certified by 01/26/2024. All future employees will be onboarded according to PLC policy and will have the required pre-employment licenses and certifications prior to being employed by the facility. DON and ADON will be re-educated by the Regional Director of Clinical Services by 01/26/2024 on requirements for CPR and Basic First Aid according to state and federal guidelines. All required guidelines will be followed by facility going forward and no future employees will be allowed to work without required licenses and certifications. All pre-employment documentation will be reviewed prior to any new employees working on the floor to ensure that all required processes, policies, and guidelines are followed. Findings will be reported to the	

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			Quality Assurance Committee. Date of compliance: 01/26/2024	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.			

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	Based on interview and record review, the facility failed to ensure 2 of 5 staff members were provided job descriptions (LPN 4) and job-specific orientation (LPN 5). Findings include: Employee records were provided by the administrator and reviewed on 12/7/23 at 10:00 a.m. A review of LPN 4's record indicated her start date was 2/6/23. Her records lacked a job description acknowledged by the staff member. A review of LPN 5's record indicated her started date was 8/9/23. Her records lacked general and specific orientation training. During an interview, on 12/7/23 at 1:25 p.m., the DON indicated she would look for LPNs 4 and 5's missing information. No further training records were provided by the facility prior to completion of survey activities.	R 0119	It is the intent of Vita of Marion that perspective employees have the proper pre-employment screenings to work in our facilities as required by 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D). The deficiency had the potential to affect all residents. All current employee files were audited on 12/28/2023 by the administrative assistant to ensure they were compliant with PLC policy. All files that were found to be out of compliance will be updated by 01/26/2024. All future employees will be onboarded according to PLC policy and will be orientated appropriately with general job specific materials. The facility will review all required documentation and ensure all new employees have been properly onboarded before working at the facility. Job specific orientation will be provided during the job specific orientation by the appropriate department head. A review of the pre-employment policy and orientation requirements will be conducted with department heads by 01/26/2024 by the ED/Designee. All required procedures in the policy will be followed by facility going forward and no future employees will be allowed to work without required documentation. All pre-employment documentation will be reviewed	01/26/2024

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			prior to any new employees working on the floor to ensure that all required processes and policies are followed related to the hiring policy. This will be initiated and conducted by the ED/Designee and will be ongoing. Findings will be reported to the Quality Assurance Committee. Date of compliance: 01/26/2024	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with			

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	dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure 2 of 5 staff members completed dementia training and resident rights training within the state required time frame (Licensed Practical Nurse (LPN) 4 and 5). Findings include: Employee records were provided by the Administrator on 12/7/23 at 10:00 a.m. A review of LPN 4's record indicated her start date was 2/6/23. She had not completed dementia training. A review of LPN 5's record indicated her started date was 8/9/23. She had not completed dementia or resident rights training. On 12/7/23 at 1:25 p.m., the DON indicated they would look for additional dementia training. No further information was provided by the facility.	R 0120	It is the intent of Vita of Marion that perspective employees have the proper pre-employment in-services and trainings to work in our facility as required by 410 IAC 16.2-5-1.4(e)(1-3). The deficiency had the potential to affect all residents. All current employee files were audited on 12/28/2023 by the administrative assistant to ensure they were compliant with PLC policy. All files that were found to be out of compliance will be updated by 01/26/2024. All future employees will be onboarded according to PLC policy and will be orientated appropriately with proper in-services and trainings provided prior to working the floor. A review of the pre-employment policy and orientation requirements will be conducted with department heads by 01/26/2024 by the ED/Designee. All required procedures in the policy will be followed by facility going forward. All pre-employment	01/26/2024

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			documentation will be reviewed prior to any new employees working on the floor and no employees will be allowed to work without required in-services and trainings being completed. This will be initiated and conducted by the ED/Designee and will be ongoing. Findings will be reported to the Quality Assurance Committee. Date of compliance: 01/26/2024 -	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to complete pre-admission evaluations to ensure appropriate placement for 3 of 7 residents reviewed for pre-admission assessments. (Residents 69, 72, and 76) Findings include: 1. Review of Resident 69's clincial record, performed on 12/6/23 at 1:38 p.m., indicated a lack of a pre-admission evaluation. During an interview with the DON, on 12/6/23 at 3:23 p.m, she indicated she was unable to find a preadmission evaluation for Resident 69. 2. Resident 72's clinical record was reviewed on	R 0214	It is the intent of Vita of Marion that preadmission assessments be completed and reviewed by nursing staff as required by 410 IAC 16.2-5-2(a) All new residents have the potential to be affected. The facility will review all prospective residents and ensure that preadmission assessments are completed and reviewed by the nursing team. A review of these assessments will be completed by the DON/Designee to ensure appropriate residents are accepted at Vita of Marion. Any concerns	01/26/2024

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	12/6/23 at 2:52 p.m. She was admitted on 7/30/23. Diagnoses included diabetes mellitus with diabetic neuropathy, essential hypertension, macular degeneration, and blindness of both eyes. Her record lacked a pre-admission evaluation. During an interview, on 12/7/23 at 11:19 a.m., the DON indicated she had no further documentation to provide for Resident 72.3. The clinical record for Resident 76 was reviewed on 12/6/23 at 1:15 p.m. Diagnoses included bipolar disorder, hypertension, type 2 diabetes mellitus, and chronic obstructive pulmonary disease. Review of the clinical record indicated the facility failed to provide pre-admission evaluation. Review of a current facility document titled "Clinical Documents Needed for Our Nursing Assessment", provided electronically by the Administrator on 12/7/23 at 8:10 p.m., indicated a list of documents needed prior to the Director of Nursing (DON) performing an in-person, clinical evaluation. The same document included a "Clinical Pre-Admission To-Do List". No clinical evaluation or "Clinical Pre-Admission To-Do List" was completed for Resident 69. Review of a current facility document, titled "Resident Rental & Service Agreements Priority Life Care", was provided by the Administrator on 12/6/23 at 10:43 a.m. and indicated the following: "...Personal Care Services, the agreement indicated the following: "Prior to your admission to the Community, the staff performed a comprehensive Resident Evaluation of your needs. We determine with you, in accordance with the results of the Resident Evaluation, the Personal Care Services that you need. Staff will reevaluate you regularly to determine any change in services...You will receive the services		for admission will be discussed at that time with the admissions team. DON and ADON will be re-educated by the Regional Director of Clinical Services by 01/26/2024 on the required preadmission assessments that need to be completed. All required preadmission assessments will be completed by the DON/Designee going forward and no future residents will be admitted with the appropriate assessments being completed. All prospective residents will be reviewed by the admissions team to ensure all preadmission assessments have been completed prior to moving in. This will be initiated by the ED/Designee and will be ongoing. Findings will be reported to the Quality Assurance Committee. Date of compliance: 01/26/2024	

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	appropriate to your individual needs, as described in your Resident Evaluation...."			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (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: (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 the resident or their representative for 7 of 7 residents reviewed for signed service plans. (Residents 20, 34, 63, 69, 72, 76, and 77)	R 0217	It is the intent of Vita of Marion that service plans be completed, reviewed, and signed by the resident/resident representative on admission and during any review	01/26/2024

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		A. BUILDING 00 B. WING	12/07/2023

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VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

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	Findings include: 1. Resident 34's clinical record was reviewed on 12/6/23 at 12:00 p.m. Her diagnoses included hypothyroidism, fibromyalgia, and diabetes mellitus without neuropathy. Her current, 5/6/23 service plan was not signed by the resident or the resident's representative. 2. Resident 76's clinical record was reviewed on 12/6/23 at 1:15 p.m. Her diagnoses included diabetes, chronic obstructive pulmonary disease, hypertension, and bipolar disorder. Her current, 1/17/23, service plan documented on admission was not signed by the resident or the resident's representative. 3. Resident 77's clinical record was reviewed on 12/6/23 at 2:40 p.m. Her diagnoses included repeated falls, atrial fibrillation, rheumatoid arthritis, and spondylosis with radiculopathy. Her current, 10/2/23, service plan documented on admission was not signed by the resident or the resident's representative. 4. Resident 72's clinical record was reviewed on 12/6/23 at 2:52 p.m. Her diagnoses included diabetes mellitus with diabetic neuropathy, essential hypertension, macular degeneration, and blindness of both eyes. Her current, 7/30/23, service plan was not signed by the resident or the resident's representative. 5. Resident 69's clinical record was reviewed on 12/6/23 at 3:00 p.m. Her diagnoses included diabetes mellitus due to underlying condition with circulatory complications, malignant neoplasm of breast, obstructive sleep apnea, essential hypertension, kidney disease stage 3, and		of resident service plans by nursing staff as required by 410 IAC 16.2-5-2(e)(1-5) All residents have the potential to be affected. The facility will review and update all resident service plans by 01/26/2024 to ensure that all resident service plans have been reviewed and signed by residents/resident representatives. This review will be completed by DON/Designee to ensure compliance. DON and ADON will be re-educated by the Regional Director of Clinical Services by 01/26/2024 on the completion and requirements of resident service plans. DON/Designee will review any update to resident service plans to ensure they have been signed by resident/resident representative on-going. Findings will be reported to the Quality Assurance Committee. Date of compliance: 01/26/2024	

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	lymphedema. Her current, 3/17/23, service plan was not signed by the resident or the resident's representative. 6. Resident 63's clinical record was reviewed on 12/6/23 at 3:59 p.m. Her diagnoses included diabetes mellitus due to underlying condition with diabetic neuropathy, end stage renal disease, obstructive sleep apnea, and atrial fibrillation. Her current, 2/3/23, service plan was not signed by the resident or the resident's representative. 7. Resident 20's clinical record was reviewed on 12/7/23 at 9:30 a.m. Her diagnoses included anxiety, schizophrenia, hypothyroidism, Parkinson's disease, diabetes, and a colostomy. Her current, 3/22/23, service plan was not signed by the resident or the resident's representative. During an interview, on 12/7/23 at 11:19 a.m., the DON indicated she had not seen a signed service plan for the residents since she started at the facility. She was unable to provide any signed service plans for the residents.			
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based upon observation, record review and interview, the facility failed to follow written policies for medication administration for 1 of 8 residents reviewed. (Resident 35) During an observation and interview, on 12/7/23 at 7:45 a.m., QMA (Qualified Medication Aid) 2 left a Jardiance 10 mg tablet (for diabetes) with the	R 0296	It is the intent of Vita of Marion that medication assistance be provided according to policies and procedures to meet the requirements of 410 IAC 16.2-5-6(b). All residents have the potential to be affected.	01/26/2024

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	resident. The QMA indicated the resident often refused to take the medication when it was delivered to her room. She frequently left the medication with the resident because the resident would refuse to take it whenever the QMA delivered the pill. A PLC Level of Care document, dated 5/12/23, indicated Resident 35 required caregiver administration and/or observation of medications requiring judgement for necessity, dosage, and/or effect, on a round the clock basis. An undated facility document titled "Priority Lifecare Medication Policy," provided by the Administrator on 12/7/23 at 8:10 p.m., indicated the following: "...Each resident has the right to self-administer his/her own medication unless determined that this practice is unsafe by the community, the resident/resident responsible party and/or physician. Medicine is to be taken regularly by the resident, as prescribed by his/her physician. Assisted supervision will be provided by the staff, if necessary, to achieve this regimen...Medication Management Program: The medication management program was designed for residents who are unable to safely manage their own medication...."		All nursing staff will be educated on Life Care's Medication Administration policy and procedures by the DON/Designee prior to 01/26/2024. Education will consist of proper dispensing, disposing of, and general medication handling requirements. The education will also detail the proper steps and procedures for documenting resident refusal to take medications. To ensure ongoing compliance the facility will initiate ongoing spot audits by the DON/Designee to ensure the Medication Administration Policy is being followed. Concerns will be addressed immediately by the DON/Designee. Findings will be reported to the Quality Assurance Committee. Date of compliance: 01/26/2024	
R 0299 Bldg. 00	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on record review and interview, the facility failed to notify the physician of pharmacy review recommendations for 3 of 7 residents sampled for medication regimen review. (Residents 63, 69, and 77)	R 0299	It is the intent of Vita of Marion that medication assistance be provided according to policies and procedures to meet the requirements of 410 IAC	01/26/2024

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	Findings include: 1. Resident 69's clinical record was reviewed on 12/6/23 at 3:00 p.m. A pharmacy recommendation, dated 10/11/23, indicated all non-steroidal anti-inflammatory drugs should be administered with food and adequate liquid to avoid gastrointestinal distress. The recommendation included a request to update the order to include that information. A physician's order for meloxicam 15 mg once a day for inflammation, dated 9/9/23 and updated on 11/29/23, did not indicate any updates. No physician notifications or approvals were indicated in the resident's clinical record. 2. Resident 77's clinical record was reviewed on 12/6/23 at 2:40 p.m. A pharmacy recommendation, dated 10/11/23, indicated the physician should provide a detailed risk versus benefit analysis for the use of oxybutynin 5 mg for incontinence or overactive bladder. Oxybutynin was not recommended for use in patients >65 years of age, due to the risk of increased sedation and anticholinergic effects. The pharmacist recommended changing to a beta-3 adrenergic receptor agonist to avoid anticholinergic effects. On 6/13/23, the pharmacist medication review of Voltaren 1% topical gel indicated the gel should be administered using a wand provided with the gel. Use of the wand would provide consistent dosing and prevent accidental over/under exposure to the medication. The pharmacist asked the provider to consider updating the order to include where the gel was to be applied and the amount to be applied.		16.2-5-6(c)(3). All residents have the potential to be affected. All current Pharmacist recommendations were reviewed by DON on 12/29/2023 to ensure all current recommendations were being followed and that physician notification had been made and documented in the clinical record for those recommendations. All nursing staff will be educated on Life Care's Medication Administration policy and procedures by the DON/Designee prior to 01/26/2024. Education will include proper procedures for notifying the resident's physician of any pharmacy recommendations made by the Consultant Pharmacist and how to document that in the clinical record. To ensure ongoing compliance the DON/Designee will review all Consultant Pharmacist recommendations, ensure the physician has been notified and then upload the audited recommendations into PCC. Concerns will be addressed immediately by the DON/Designee. Findings will be reported to the Quality Assurance Committee. Date of compliance: 01/26/2024	

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	Further review of the resident's clinical record indicated no physician approvals or changes. During an interview, dated 12/7/23 at 11:23, the DON indicated she did not have any physician notifications or approvals related to pharmacy recommendations for Residents 69 or 77.3. Resident 63's clinical record was reviewed on 12/6/23 at 3:59 p.m. Her diagnoses included diabetes mellitus due to underlying condition with diabetic neuropathy, end stage renal disease, obstructive sleep apnea, and atrial fibrillation. Review of the 10/11/23 pharmacist's medication regimen review recommendation, provided by the DON on 12/7/23 at 10:30 a.m., indicated the resident had an order for daily montelukast (used for asthma). The pharmacist recommended the administration time be changed to bedtime per manufacturer's recommendation to minimize side effects. The resident's clinical record indicated an order for montelukast sodium 10 mg at 8 a.m. every Tuesday, Thursday, Saturday, and Sunday related to asthma (ordered 2/15/23, started 2/17/23). The progress notes lacked documentation of the physician's notification of the pharmacist's recommendation for the change. During an interview, on 12/7/23 at 2:39 p.m., the DON indicated the nurse was responsible for notification of the physician with pharmacy recommendations. The recommendation was made prior to her start date at the facility so she was uncertain who may have notified the physician. She was unable to locate documentation of the physician notification.			

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R 0378 Bldg. 00	410 IAC 16.2-5-11.1(b)(1)(A-H)(2-3) Mental Health Screening- Deficiency (b) If the individual is a recipient of Medicaid or federal Supplemental Security Income (SSI), the individual needs evaluation provided in section 2(a) of this rule shall include, but not be limited to, the following: (1) Screening of the individual for major mental illness, such as a diagnosed major mental illness, is limited to the following disorders: (A) Schizophrenia. (B) Schizoaffective disorder. (C) Mood (bipolar and major depressive type) disorder. (D) Paranoid or delusional disorder. (E) Panic or other severe anxiety disorder. (F) Somatoform or paranoid disorder. (G) Personality disorder. (H) Atypical psychosis or other psychotic disorder (not otherwise specified). (2) Obtaining a history of treatment received by the individual for a major mental illness within the last two (2) years. (3) Obtaining a history of individual behavior within the last two (2) years that would be considered dangerous to facility residents, the staff, or the individual. Based on record review and interview, the facility failed to perform a mental health screening for 2 of 7 residents reviewed who receive Medicaid services. (Residents 63 and 77) Findings include: 1. Resident 77's clinical record was reviewed on 12/6/23 at 2:40 p.m. Diagnoses included chronic obstructive pulmonary disease, myalgia, repeated falls, rheumatoid arthritis, lumbosacral spondylosis with radiculopathy, dysphagia, and	R 0378	It is the intent of Vita of Marion that all new residents with a history of mental illness or current residents with a new diagnosis of mental illness receive the proper mental health screening as required by 410 IAC 16.2-5-11.1(b)(1)(A-H)(2-3) All new residents and current residents have the potential to be affected. The facility NP will evaluate all new admissions for	01/26/2024

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	unspecified atrial fibrillation. They received Medicaid services. The resident lacked a mental health screening. 2. Resident 63's clinical record was reviewed on 12/6/23 at 3:59 p.m. Her diagnoses included diabetes mellitus due to underlying condition with diabetic neuropathy, end stage renal disease, obstructive sleep apnea, and atrial fibrillation. She was a recipient of Medicaid. The resident lacked a mental health screening. During an interview, on 12/7/23 at 11:19 a.m., the DON indicated she was unable to locate documentation of a mental health screening for the resident.		mental illness, psychotropic drug use, and behaviors upon admission. If appropriate, NP refers those residents to facility psych provider. The psych provider will obtain a history which covers the previous two years and develop a plan for treatment for that resident. Residents identified will be seen biweekly by psych provider to ensure treatment plan is effective and resident's needs are being met. This process will be followed with any in house resident who receives a new diagnosis of a major mental illness, develops behaviors, or is placed on psychotropic medications. DON/Designee will meet bimonthly with psych provider to ensure all residents being seen by provider have a current treatment plan and that plan is successful. Concerns and recommendations will be addressed at that time. DON and ADON will be educated by the Regional Director of Clinical Services by 01/26/2024 on this new process. All required mental health screenings will be completed by the appropriate mental health care provider going forward. This process will be ongoing. Findings will be reported to the Quality Assurance Committee. Date of compliance: 01/26/2024	

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R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (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 interview and record review, the facility failed to ensure residents received a tuberculin skin test prior to admission for 1 of 7 residents (Resident 20). Findings include: Review of Resident 20's clinical record was completed on 12/6/23 at 12:15 p.m. Diagnoses included anxiety, schizophrenia, hypothyroidism, cognitive communication deficit, Parkinsons disease, diabetes, and colostomy. Review of the clinical record indicated resident failed to have a two-step Tuberculin skin test prior to admission. During an interview, on 12/7/23 at 11:06 a.m., the	R 0410	It is the intent of Vita of Marion that all new residents have received a tuberculin skin test prior to admission as required by 410 IAC 16.2-5-12(e)(f)(g) All new residents have the potential to be affected. The facility will review all prospective residents and ensure that preadmission assessments are completed and reviewed by the nursing team to include a tuberculin skin test within 3 months prior to admission. A review of these assessments will be completed by the	01/26/2024

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	DON indicated she didn't have tuberculin skin test records for the resident. An undated facility policy, provided by the administrator, on 12/7/23 at 8:10 p.m., and titled "Mantoux Testing Policy" indicated "All assisted living residents will have a two step Mantoux within three days of admission unless one was completed within three months of admission to the residence ...."		DON/Designee to ensure appropriate residents are accepted at Vita of Marion. Any concerns for admission will be discussed at that time with the admissions team. DON and ADON will be re-educated by the Regional Director of Clinical Services by 01/26/2024 on the required preadmission assessments that need to be completed. All required preadmission assessments will be completed by the DON/Designee going forward and no future residents will be admitted with the appropriate assessments being completed. All prospective residents will be reviewed by the admissions team to ensure all preadmission assessments have been completed prior to moving in. This will be initiated by the ED/Designee and will be ongoing. Findings will be reported to the Quality Assurance Committee. Date of compliance: 01/26/2024	