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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00438443, IN00438206, IN00438095, IN00437861, IN00437891, IN00437097, and IN00436421. Complaint IN00438443 - State deficiencies related to the allegations are cited at R0297. Complaint IN00438206 - State deficiencies related to the allegations are cited at R0297. Complaint IN00438095 - State deficiencies related to the allegations are cited at R0052. Complaint IN00437861 - State deficiencies related to the allegations are cited at R0297. Complaint IN00437891 - State deficiencies related to the allegations are cited at R0297. Complaint IN00437097 - No deficiencies related to the allegations are cited. Complaint IN00436421 - No deficiencies related to the allegations are cited. Survey dates: July 9, 10, and 11, 2024. Facility number: 015081 Residential Census: 78 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 17,2024.	R 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Wiley	RDCS	08/18/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (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 observation, interview, and record review, the facility failed to protect a cognitively impaired resident from neglect related to elopement from the facility memory care unit and into the unsupervised courtyard when the secured door alarm was turned off or the volume was lowered, rendering it ineffective to alert staff to the door being breached. (Resident H) Findings include: Review of a 7/4/24 facility self-reported incident indicated on 7/3/24 at 7:17 p.m., Resident H was found to have left the secured unit, was outside briefly, and assisted back into the facility by the receptionist. During an observation on 7/10/24 at 2:08 p.m., accompanied by the Memory Care Coordinator, the locked memory care (MC) door was pushed, the alarm rang, and after about 15 seconds the door released, allowing access to the lobby. Afterward, a very loud alarm rang and three Certified Nursing Assistants (CNAs) responded within 10 seconds. The coordinator indicated staff needed to be vigilant to ensure the door locked when leaving the secured unit. One of the residents, Resident H, would sit by the door, watch for someone to exit, and proceed through the door before it locked again. The administrator's badge was required to silence the	R 0052	1. The residents that are found to be have been affected by this deficient practice will be reassessed by the community to determine their wander risk, and whether the community can continue to meet their needs. 2. The community will conduct a head count of all memory care residents at shift change and reassess all residents on memory care to determine the cognition ability of each resident and their wander risk. Staff will be in-serviced on the secured door alarm, keypad and elopements by the executive director or designee monthly for six months. The facility will also conduct these in-services with new employees on hire, annually, and as needed for ongoing training. The executive director or designee will randomly conduct elopement drill ensure compliance. 3. The exit door on memory care has been switched over to a manual keypad for entry and exit. The door will be checked daily by the maintenance director or designee. To ensure compliance	08/31/2024

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	alarm. Resident H's clinical record was reviewed on 7/10/24. Diagnoses included unspecified dementia of unspecified severity without behavioral disturbance, glaucoma, and cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery. The clinical record included an admission wandering risk assessment that indicated the resident was at moderate risk of wandering due to her short attention span, unfamiliarity with her surroundings, recent admission, diagnosis of early dementia, and a known history of wandering. An admission Brief Interview for Mental Status (BIMS) indicated the resident was severely cognitively impairment. During an interview on 7/11/24 at 11:51 a.m., the Regional Director of Operations indicated Resident H was found walking around in the assisted living area by another resident. After he reviewed the video from the incident, he determined the alarm on the exit door had been deactivated during a move for another resident. The deactivated alarm allowed Resident H to freely walk out of the memory care unit. The alarm was reactivated afterwards. He was unsure if memory care residents were allowed to go into the lobby which had an unlocked door into the facility. He confirmed the door going out of lobby and into the facility was not locked. The facility planned to get a keypad for the locked doors on the memory care unit. No changes to the alarming system had been made at the time of the observation. A facility incident note was reviewed on 7/11/24 at		the maintenance director or designee will complete a memory care door audit form daily. The audit and findings will be discussed at monthly IDT meetings. The ED or designee will determine if continued auditing is necessary based on six consecutive months of compliance. Monitoring will be on-going. 4. The maintenance director or designee will inspect door mounting and operation and inspect panic hardware, verify system code and keypad operation daily.	

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3:02 p.m. The nursing description indicated the resident was found by other residents in the assisted living courtyard. The resident indicated she just wanted to look around. The clinical record lacked indication of the resident leaving the secured unit, being outdoors, and returning to the unit with the assistance of the receptionist. The clinical record lacked indication of a physical assessment, notifications to the resident representative and medical provider, or follow-up measures provided for Resident H. During an interview, on 7/11/24 at 3:09 p.m., the MC Director and the Life Enrichment Director indicated the alarm from the memory care unit to the outside facility is at the top of the door and if someone was tall enough, it could be turned off. If family members disabled the alarm, they were supposed to notify staff and staff was supposed to sit at the door the entire time it was disabled and enable it before leaving the area. Neither staff member was aware of how long the alarm to the outside was deactivated when Resident H eloped. During an observation, on 7/11/24 at 3:35 p.m., the Life Enrichment Director turned the alarm on the outside door of the memory care unit to low and was able to open door after 15 seconds. The alarm was switched back to the loud volume and the door was opened. Four minutes elapsed before a staff member came back to the exit to evaluate the alarm. During an interview, on 7/11/24 at 3:43 p.m., the Regional Director of Operations and the Administrator indicated they did not hear the loud alarm activated in the memory care unit at 3:35			

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	p.m. Neither was aware the alarm on the locked door going to the outside could be switched to a lower volume nor that the door could be opened after 15 seconds. It was not until Resident H eloped from the unit on 7/3/24 that they became aware. Both indicated the door could currently still be accessed in the same way. A current facility policy, titled "Priority Life Care: Missing Resident/ Elopement Policy and Procedure," dated 6/29/2018 and provided by the Regional Director of Operations on 7/11/14 at 4:20 p.m., indicated "...an elopement is the unauthorized exit of a resident, who lacks the necessary cognitive skills to maintain individual safety, from the community without adequate supervision, or staff awareness ...." This citation relates to Complaint IN00438095.			
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 and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to obtain references and criminal history background checks for 2 of 27 employees reviewed for employee records. (QMA 4, and LPN 5) Findings include: A review of current employee records was performed on 7/10/24 at 1:08 p.m.	R 0116	The corrective action taken for those residents found to have been affected by the deficient practice is that all residents have the potential to be affected by this deficient practice. A criminal background check has now been submitted on the nurse identified as LPN 5 and the QMA identified as QMA 4 through the Indiana	08/31/2024

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 7/10/24, at 4:16 p.m., the Operations Specialist provided personnel records for QMA 4 and LPN 5. QMA 4's personnel file lacked a pre-hire background check or references. She was hired on 4/10/2024. LPN 5's personnel file lacked a pre-hire background check or any references. She was hired on 5/9/2024. No documentation or information regarding pre-employment screening was provided by the facility. During an interview with the Operations Specialist, on 7/10/24 at 4:47 p.m., she indicated the only information available for both employees was what was in the personnel files she had previously provided.		State Police Repository. Reference checks have also been completed for LPN 5 and QMA 4 and added to their employee files. The facility will not employ persons with criminal findings in accordance with applicable regulation. Documentation of the criminal background investigation shall be maintained in the employee file. All residents had the potential to be affected by this deficient practice. The administrative assistant will review all staff files to ensure that references and background checks have been completed for all staff. Any staff members that do not have completed reference checks or background check screenings on file will be rectified. The administrative assistant was re-educated on 08/01/2024 on the Indiana State rule requiring references and background checks be obtained for all new hires upon hire. Current staff who are identified as not having completed references or completed background checks, the administrative assistant will work to obtain those references and background checks retroactively. The administrative assistant will ensure that references and background checks are obtained for new hires during the hiring process. The administrative assistant will	

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			be responsible for sustained compliance. The administrative assistant/designee will complete audits for all new hires prior to their start date. The audit and findings will be discussed at monthly IDT meetings. The administrative assistant or ED will determine if continued auditing is necessary based on six consecutive months of compliance. Monitoring will be on-going. ="" p="">	
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			

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 a first-aid certified staff member was on site for seven of forty two shifts reviewed for staffing. Findings include: A review of staffing schedules for the prior seven days, provided by the Operations Specialist, was completed on 7/10/24 at 3:40 p.m. On 7/3/24, no first aid certified staff were present for a 24-hour period (all shifts). On 7/5/24, no first aid certified staff were present during first or third shift. On 7/6/24, no first aid certified staff was present during third shift.	R 0117	div class="TableCellContent SCXW111891129 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 1px 7px 3px; user-select: text; overflow: visible;" What has been done to correct? An audit was completed to ensure all clinical staff have a CPR/First Aid certification. The scheduler was trained to include indicators of appropriate CPR/FA certifications next to each staff member's name on the daily schedule. See attached forms.div class="TableCellContent SCXW111891129 BCX8" style="-webkit-user-drag: none;	08/31/2024

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 7/7/24, no first aid certified staff was present during third shift. During an interview on 7/11/24 at 4:22 p.m., the Clinical Operations Specialist indicated no other certifications were available.		-webkit-tap-highlight-color: transparent; margin: 0px; padding: 1px 7px 3px; user-select: text; overflow: visible;" How will recurrence be prevented? The daily schedule will contain CPR/FA next to all staff for the day who have CPR/First aid certifications. The ED or designee will work with the scheduler to ensure there is adequate coverage per 24hr period. Dailies will be reviewed weekly with the scheduler to ensure adequate coverage. The weekly schedule review will continue indefinitely. div class="TableCellContent SCXW111891129 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 1px 7px 3px; user-select: text; overflow: visible;" Person Responsible: ED or designee div class="TableCellContent SCXW111891129 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 1px 7px 3px; user-select: text; overflow: visible;" Due Date: 8/31/2024	
R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of			

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide.			
	Based on interview and record review, the facility failed to ensure a Certified Nursing Assistant had a current certification for 1 of 27 employees reviewed for employee records. (CNA 2) A review of current employee records, provided by the Operations Specialist, was performed on 7/10/24 at 1:08 p.m. CNA 2's certification expired on 3/31/24 according to the Indiana Professional Licensing Agency, located on-line at https://www.in.gov/pla/license/free-search-and-verify. During an interview with the Regional Director of Clinical Services, on 7/10/24 at 3:46 p.m., she indicated she had recently been made aware of the expired certification.	R 0118	An audit was completed to ensure al staff had valid licenses. Staff members who did not have a valid license were renewed. DON or designee will keep a binder with all staff licenses listed by the month they expire. DON or designee will notify all staff when it is time to renew their licenses. Staff will be removed from the schedule if they have expired licenses and not allowed to return for duty until their licenses are renewed. DON or designee will audit this binder at the beginning of each month indefinitely.	08/31/2024
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;			

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(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.			
	Based on interview and record review, the facility failed to provide employees with general and job-specific orientation for 2 of 5 employees reviewed for employee records. (LPN 5 and QMA 4) Findings include: A review of current employee records was performed on 7/10/24 at 1:08 p.m. LPN 5 was hired on 5/9/2024. Her personnel file lacked both a general and specific job orientation. No job description was provided for the employee.	R 0119	**All current employee files were audited by the administrative assistant to ensure compliance with PLC policy. All files that were found to be out of compliance have been be updated.** **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**	08/31/2024

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	QMA 5 was hired on 4/10/2024. Her personnel file lacked both a general and specific job orientation. No job description was provided for the employee. During an interview with the Operations Specialist, on 7/10/24 at 4:47 p.m., she indicated the only information available for both employees was what was in the personnel files she had previously provided.		**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 by the ED/Designee. All required procedures in the policy will be followed by the community. The facility will use the Employee Records state form 5440 as compliance tool for all new hire employee records. New hire orientation schedules will be reviewed by IDT team during morning stand up meetings as needed to ensure all necessary documentation has been completed in the appropriate time frames. The administrative assistant is responsible for maintaining employee records, along with department supervisors will be educated upon hire on the required orientation requirements. Education was also completed with the administrative assistant regarding orientation and job descriptions on 08/01/2024 to ensure compliance. /p> All pre-employment documentation will be reviewed prior to any new**	

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			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.**	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers 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 one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive			

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to perform health screenings and 2-step tuberculosis (TB) testing prior to employment for 2 of 27 employees reviewed for health screenings. (QMA 4 and LPN 5) Findings include: A review of current employee records was completed on 7/10/24 at 1:08 p.m. QMA 4's personnel file lacked a health screen or a 2-step TB test. She was hired on 4/10/2024. LPN 5's personnel file lacked a health screen or a 2-step TB test. She was hired on 5/9/2024. Both LPN 4 and QMA 4 have been working at the facility on a regular basis. No documentation or information regarding health screens or TB testing for QMA 4 and LPN 5 was provided by the facility. During an interview with the Operations Specialist, on 7/10/24 at 4:47 p.m., she indicated the only information available for both employees	R 0121	An audit was completed to ensure all employees had a health screen done and a 2-step TB or chest x-ray. All staff will have a 2-step TB or chest x-ray prior to starting in the facility. DON or designee will create a binder divided by month of hire to keep track of upcoming annual screenings. Binder will be audited monthly indefinitely.	08/31/2024

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was what was in the personnel files she had previously provided. 410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure medications were administered to residents during scheduled times for 7 of 7 residents reviewed for late and missed medications (Resident B, Resident C, Resident F, Resident H, Resident J, Resident K, and Resident L). Findings include: 1. Resident B's clinical record was reviewed on 7/10/24 at 10:02 a.m. Diagnoses included, but were not limited to, atrial fibrillation, insomnia, dementia with moderate anxiety, benign prostatic hyperplasia with lower urinary tract symptoms, major depressive disorder, hyperlipidemia, vitamin B 12 deficiency and vitamin D deficiency. Current medications included, but were not limited to, metoprolol tartrate (high blood pressure) 25 milligram (mg) twice daily, aspirin 81 mg daily, simvastatin (high cholesterol) 10 mg daily, vitamin B-12 1000 microgram (mcg) daily, vitamin D3 25 mcg twice daily, and Lexapro (depression) 10 mg daily. A Medication Administration Report of missed medications, for July 2024 indicated his 8:00 a.m.			
R 0297 Bldg. 00		R 0297	What has been done to correct? An audit was completed to ensure medications were being signed out in the EMAR as administered. All Staff will be educated in signing out all items on EMAR prior to the end of their shift. Staff will be educated in notifying the MD of missed doses and obtaining new orders and/or documenting the MD's approval of missed medication. All staff will be in serviced weekly until 100 percent compliance is achieved. Audits will be conducted biweekly for 2 months, weekly for 2months, then monthly indefinitely with our QA audits. How will recurrence be prevented? DON or designee will review EMAR daily to ensure all medications have been signed out/administered indefinitely. Education and disciplinary action up to and including termination to be administered as needed to ensure compliance. See attached in services.Person Responsible: DON or	08/31/2024

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dose of medication were documented as missed one time. 2. Resident C's clinical record was reviewed on 7/10/24 at 9:30 a.m. Diagnoses included, but were not limited to, atrial fibrillation, hypothyroidism, Parkinson's disease, psychotic disorder with hallucinations, dementia, impulsiveness and anxiety. Current medications included, but were not limited to, aspirin 81 mg daily, levothyroxine (thyroid) 25 mcg daily, Nuplazid (antipsychotic) 34 mg twice daily, Rivastigmine (memory loss) 9.5 mg/24 HR patch daily, slow-release iron 45 mg daily, carbidopa-levodopa (Parkinson's) 25-100 mg five times a day, and buspirone (anti-anxiety) 15 mg three times a day. A Medication Administration Report of missed medications, for February 2024 included, but were not limited to, her 7:00 a.m. doses of medication were documented as missed medications one time, and her 8:00 a.m. doses of medications were documented as missed medications one time. A Medication Administration Report of missed medications, for March 2024 included, but were not limited to, four doses of her 12:00 p.m. and two doses of her 2:00 p.m. carbidopa- levodopa medications were not administered. A Medication Administration Report of missed medications, for July 2024 included, but were not limited to, her 7:00 a.m. doses of medications were documented as missed medications one time, and her 8:00 a.m. doses of medications were documented as missed medications one time. 3. Resident F's clinical record was reviewed on		designee Due Date: 8/31/2024 div="" div="" div="" div=""	

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	7/9/24. Diagnoses included, but were not limited to, hyperlipidemia, type 2 diabetes mellitus, primary hypertension, mild cognitive impairment of uncertain or unknown etiology, unspecified cerebrovascular disease. Current medication included, but were not limited to, losartan potassium (high blood pressure) 50 mg, carvedilol (high blood pressure) 6.25 mg twice daily, amlodipine (high blood pressure) 5 mg daily, Novolog (insulin) subcutaneous per sliding scale, and Levemir (insulin) 8 units subcutaneously daily. An April 2024 Medication Administration Report indicated, two of his 12:00 p.m. Lantus doses were not administered, two doses of his 12:00 p.m. sliding scale Novolog were not administered. A May 2024 Medication Administration Report indicated, four of his 12:00 p.m. Lantus doses were not administered, five doses of his 12:00 sliding scale Novolog were not administered. A June 2024 Medication Administration Report indicated, five of his 12:00 p.m. Lantus doses were not administered, five doses of his 12:00 sliding scale Novolog were not administered. There were no documented blood glucose checks for 4/15/24 at 12:00 p.m., 4/16/24 at 12:00 p.m., 4/21/24 at 12:00 p.m., 4/26/14 at 12:00 p.m., 4/27/24 at 12:00 p.m., 5/3/24 at 12:00 p.m., 5/14/24 at 12:00 p.m., 5/19/24 at 12:00 p.m., 5/31/24 at 12:00 p.m., 6/7/24 at 12:00 p.m., and 6/8/24 at 12:00 p.m. During an interview, on 7/9/24, Resident F indicated he had to go get his medications himself. He was told there were no staff available. He was able to get his medications, but they were			

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administered late. 4. Resident H's clinical record was reviewed on 7/10/24 at 12:00 p.m. Diagnoses included, but were not limited to, glaucoma, essential primary hypertension, cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, hypothyroidism, anemia in chronic kidney disease, gastroesophageal reflux disease, unspecified dementia, unspecified severity without behavioral disturbance. Current medications included, but were not limited to, amlodipine besylate (high blood pressure) 10 mg daily, aspirin 81 mg daily, levothyroxine (hypothyroidism) 112 mcg daily, atorvastatin calcium (high cholesterol) 40 mg daily, terazosin HCL (high blood pressure) 1 mg daily, and Sevelamer HCL (used to treat too much phosphate in blood in patients with chronic kidney disease who are on dialysis) 800 mg before meals. A Medication Administration Report of missed medications, for July 2024 included, but were not limited to, her 8:00 a.m. doses of medications were documented as missed medications one time. 5. Resident J's clinical record was on 7/10/24 at 3:15 p.m. Diagnoses included, but were not limited to, chronic fatigue, Vitamin B12 deficiency, anxiety disorder, restless leg syndrome, chronic obstructive pulmonary disease, essential primary hypertension, major depressive disorder, hyperlipidemia. Current medications included, but were not limited to, aspirin 81 mg daily, meloxicam 7.5 mg daily, clonazepam 0.5 mg daily, losartan potassium (high blood pressure) daily, metoprolol tartrate (high blood pressure) daily, trazodone (anti-anxiety) 50			

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	mg daily, buspirone (anti- anxiety) three times a day, and sertraline (depression) 200 mg daily. A Medication Administration Report of missed medications, for May 2024 included, but were not limited to, her 8:00 p.m. doses of medications were documented as missed medications one time. A Medication Administration Report of missed medications, for June 2024 included, but were not limited to, her 8:00 p.m. doses of medications were documented as missed medications one time. A Medication Administration Report of missed medications, for July 2024 included, but were not limited to, her 8:00 a.m. doses of medications were documented as missed medications one time. During an interview, on 7/11/24 at 9:40 a.m., Resident J indicated medications have been administered incorrectly and even late. There were times blood pressures had not been checked prior to him receiving his blood pressure medication. 6. Resident K's clinical record was reviewed on 7/10/24 at 2:03 p.m. Diagnoses included, but were not limited to, essential hypertension, secondary Parkinson's disease, chronic pain, hyperparathyroidism, paroxysmal atrial fibrillation, chronic kidney disease stage 3. Current medication included, but were not limited to, meloxicam (nonsteroidal anti-inflammatory) 7.5 mg daily, metoprolol tartrate (high blood pressure) 25 mg daily, tizanidine HCL (muscle relaxer) 2 mg twice daily, gabapentin (anticonvulsant and nerve pain) 600 mg twice daily, and carbidopa- levodopa (Parkinson's disease) 25-100 mg three times a day. A Medication Administration Report of missed			

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medications, for May 2024 included, but were not limited to, his 8:00 p.m. doses of medications were documented as missed medications one time. A Medication Administration Report of missed medications, for June 2024 included, but were not limited to, his 8:00 p.m. doses of medications were documented as missed medications one time. A Medication Administration Report of missed medications, for July 2024 included, but were not limited to, his 8:00 a.m. doses of medications were documented as missed medications one time. 7. Resident L's clinical record was on 7/11/24 at 4:03 p.m. Diagnoses included, but were not limited to, vascular dementia, chronic respiratory failure, and type 2 diabetes. Current medication included, but were not limited to, acetazolamide (edema) 250 mg twice a day, atenolol (high blood pressure) 25 mg daily, divalproex (seizures) 250 mg twice daily, torsemide (edema) 20 mg daily, Lantus (insulin) inject 68 units subcutaneous, ropinirole HCL (restless legs) 4 mg four times a day, carbidopa- levodopa (Parkinson's) 25-100 mg daily, Victoza (insulin) inject 0.6 units subcutaneously once daily, Myrbetriq (overactive bladder) 50 mg daily, and cefdinir (antibiotic) 300 mg twice daily. A May 2024 Medication Administration Report indicated, one of her 8:00 p.m. Victoza doses were not administered and one dose of her 12:00 p.m. Lantus were not administered. A June 2024 Medication Administration Report indicated, five of her 8:00 p.m. Victoza doses were not administered, one dose of her 8:00 a.m. Lantus and five doses of her 8:00 p.m. Lantus were not			

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administered. Her 4:00 p.m. doses of medications were documented as missed medications three times. A July 2024 Medication Administration Report indicated, four of her 8:00 p.m. Victoza doses were not administered, one dose of her 8:00 a.m. Lantus and four doses of her 8:00 p.m. Lantus were not administered. Her 4:00 p.m. doses of medications were documented as missed medications two times. There were no documented blood sugars for 5/25/24 at 8:00 p.m., 6/6/24 at 8:00 p.m., 6/10/24 at 8:00 p.m., 6/17/24 at 8:00 a.m., 6/18/24 at 8:00 p.m., 6/20/24 at 8:00 p.m., 6/26/24 at 8:00 p.m., During an interview, on 7/10/24 at 4:04 p.m., the Administrator indicated the facility had been having problems with agency nurses not administering medications to the residents. During an interview, on 7/11/24 at 11:04 a.m., the Regional Director of Clinical Services indicated at times they have QMAs (Qualified Medication Aide) who are not certified to administer insulin that work when there is not a nurse in the facility. When that happens, the QMA could either call the nurse who lives a few minutes from the facility or call the DON to come in and administer the insulins. During an interview, on 7/11/24 at 3:10 p.m., QMA 6 indicated she was contracted in through an agency. She was not able to administer insulin. She would contact the DON or her agency scheduler and notify them if she was unable to administer any residents' medications. She was able to log into the facility's charting system to document medication administration.			

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A current policy, titled "Resident Medication Administration," provided by the Clinical Operations Specialist, on 7/10/24 at 11:34 a.m., indicated medications would be administered as prescribed, and to ensure all prescribed medications in the dosage and the intervals prescribed by a provider are administered to the resident. This citation relates to Complaints IN00437861, IN00437891, IN00438206, and IN00438443.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on interview and record review, the facility failed to provide education regarding immunizations to 1 of 3 residents reviewed for infection control. (Resident F) Findings include: During a clinical record review, performed on 7/9/24 at 3:34 p.m., Resident F's record lacked information about influenza, pneumococcal, or COVID-19 immunizations.	R 0407	div class="TableCellContent SCXW60231562 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 7px; user-select: text; overflow: visible;" What has been done to correct? Audits were conducted to ensure immunizations were offered/provided to residents including education on each	08/31/2024

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The clinical record lacked information pertaining to the offering or administration of immunizations, including educational information or consents. During an interview with the Clinical Operations Specialist, on 7/11/24 at 11:06 a.m., she indicated any information pertaining to immunizations would be in the resident's clinical health records. If it was not there, the facility did not have the information.		immunization. An immunization clinic to include flu, pneumonia, and covid vaccinations was set up with Synchrony who will provide all vaccinations. These clinics will be offered yearly to ensure compliance. See attached in-service.div class="TableCellContent SCXW60231562 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 7px; user-select: text; overflow: visible;" How will recurrence be prevented? All administered vaccinations will be entered into Point Click Care. PCC (Point Click Care) will flag when each immunization is due. DON or designee will run immunizations reports weekly indefinitely to ensure compliance. div class="TableCellContent SCXW60231562 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 7px; user-select: text; overflow: visible;" Person Responsible: DON or designee div class="TableCellContent SCXW60231562 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 7px; user-select: text; overflow: visible;"	

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Due Date: 8/31/2024	
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 complete Tuberculin skin tests after admission for 3 of 12 residents reviewed (Resident F, Resident J, and Resident K). Findings include: 1. Review of Resident F's clinical record was completed on 7/9/24. Diagnoses include, but are not limited to, hyperlipidemia, type 2 diabetes mellitus, essential (primary) hypertension, mild cognitive impairment of uncertain or unknown	R 0410	div class="TableCellContent SCXW1807159 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 7px; user-select: text; overflow: visible;" What has been done to correct? An audit was completed to ensure all residents complied with their 2-step TB/chest x-ray and/or annual screening. Residents who were found out of compliance will	08/31/2024

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	etiology, and unspecified cerebrovascular disease. Review of the clinical record indicated the facility failed to complete a first and second step Tuberculin skin test prior to or after Resident F's admission. 2. Review of Resident K's clinical record was completed on 7/10/24 at 2:03 p.m. Diagnoses include, but are not limited to, essential hypertension, Parkinson's, chronic pain, paroxysmal atrial fibrillation and chronic kidney disease stage 3. Review of the clinical record indicated the facility failed to complete a second step Tuberculin skin test after admission. 3. Review of Resident J's clinical record was completed on 7/10/24 at 3:00 p.m. Diagnoses include, but are not limited to, chronic obstructive pulmonary disease (COPD), essential hypertension, chronic fatigue, and major depressive disorder. Review of the clinical record indicated the facility failed to complete a second step Tuberculin skin test after admission. During an interview, on 7/11/24 at 11:42 a.m., the Clinical Operations Specialist indicated they were unable to provide documentation regarding additional Tuberculin skin tests for Resident F, Resident J, and Resident K. An undated facility policy, provided by the DON, on 7/11/24 at 12:45 p.m., and titled "Mantoux Testing Policy" indicated "...All assisted living residents will have a two-step Mantoux within		be given the 2-step TB immunization and education on this vaccination. div class="TableCellContent SCXW1807159 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 7px; user-select: text; overflow: visible;" How will recurrence be prevented? All administered vaccinations including (TSTs) will be entered into Point Click Care. PCC (Point Click Care) will flag when each immunization is due. DON or designee will run an immunization report weekly to ensure compliance. This report will be completed weekly indefinitely. See attached in service.div class="TableCellContent SCXW1807159 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 7px; user-select: text; overflow: visible;" Person Responsible: DON or designee div class="TableCellContent SCXW1807159 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 7px; user-select: text; overflow: visible;" Due Date: 8/31/2024	

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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	three days of admission unless one was completed within three months of admission to the residence ...."			