DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	03/31/2025

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 the Investigation of Complaints IN00455754, IN00455760, and IN00455445. Complaint IN00455754 - State deficiencies related to the allegations are cited at R0273 and R0116. Complaint IN00455760 - State deficiencies related to the allegations are cited at R0299 and 0273. Complaint IN00455445 - State deficiencies related to the allegations are cited at R0299. Unrelated deficiencies are cited. Survey dates: March 28 and 31, 2025 Facility number: 015081 Residential Census: 90 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 4, 2025.	R 0000		
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance Based on observation, interview, and record review the facility failed to ensure an employee with a criminal history of theft was not employed by the facility. This deficient practice had the potential to impact 90 of 90 residents. Findings Include: Employee records were reviewed on 3/31/25 at	R 0116	Employee DE1 is no longer employed at the community. The Executive Director will in-service the Business Office Manager on the Abuse policy and Criminal Background check policy.	05/09/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dustin Newsome	Executive Director	04/18/2025

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	03/31/2025

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
	9:30 a.m. Dietary Employee 1 (DE 1) was employed by the current management agency on 9/9/24. Employee DE 1 had a criminal history check completed on 1/19/24, which indicated they had been convicted of the following: Offense Date: 3/26/20 File Date: 7/27/20 Disposition Date: 9/17/20 Charge: Theft Disposition: Plea Guilty Type of Crime: Misdemeanor Class A 361 Days Informal Probation. During an interview on 3/31/25 at 1:00 p.m., the Administrator indicated the new management company had began operating in September of 2024. To his knowledge, an audit of employee record had not been completed at that time. He began his position in October 2024. He had not been aware of DE 1's history of theft. Employees with a history of theft in the last 5 years should not be employed by the facility. A current, 3/2025, facility policy titled, "Health Care Worker Background Check Policy," provided by the DON on 3/31/25 at 3:15 p.m., indicated: "...The Health Care Workers Background Checks are conducted to support workplace and community safety and security for the Residents, Resident Families, and Staff...." A current, 1/2022, facility policy titled, "Abuse, Neglect, and Financial Exploitation Prevention," provided by the DON on 3/28/25 at 2:42 p.m., indicated: "...Screening...All staff will undergo a criminal background check ....All staff must receive favorable results from the screenings in		The Business Office Manager/ designee conducted an audit to ensure background checks were completed as stated in the regulation. No other personnel's criminal background check was found to be in violation of the regulation. Audit of new employee criminal background checks will be completed weekly x's 4 weeks and monthly x's 6 months. Variances will be corrected at the time of observation, and audits will be reviewed by the community's QAPI committee.	

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	03/31/2025

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
	order to join the staff or continue employment...." This citation relates to complaint IN00455754.			
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance Based on interview and record review, the facility failed to ensure employees received six hours of dementia education within the first six months of employment. Findings include: Employee records were reviewed on 3/31/25 at 9:30 a.m. and indicated the following: a.) Dietary Employee 1 (DE 1), with a hire date of 9/9/24, lacked six hours of dementia training within six months of hire. b.) Housekeeper 2 (H 2), with a hire date of 9/9/24, lacked six hours of dementia training within six months of hire. c.) QMA 3, with a hire date of 9/9/24, lacked six hours of dementia training within six months of hire. d.) QMA 4, with a hire date of 9/9/24, lacked six hours of dementia training within six months of hire. During an interview on 3/31/25 at 3:05 p.m., the DON indicated the facility required all employees to complete dementia training in accordance with state requirements. A current, 6/2022, facility policy titled, "Staff Training Policy and Procedure," provided by the	R 0119	All staff who were found to be in violation of the regulation have been assigned the 6- hour dementia education. The Executive Director/ designee conducted an audit of the required dementia education training and assigned the required 6-hour training to each staff member identified. All staff will have completed the required 6-hour training prior to the date of compliance. The Executive Director/ Designee will audit the dementia education weekly x4 weeks then monthly x6 months. Variances will be corrected at the time of observation, and findings will be reviewed by the community's QAPI committee.	05/09/2025

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	03/31/2025

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
	DON on 3/31/25 at 3:18 p.m., indicated: "...It is the responsibility of the Administrator or designee to maintain training, education, and in-service records summarizing content and attendance...."			
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance Based on interview and record review, the facility failed to ensure employees completed job-specific orientation within 30 days of hire. This deficient practice had the potential to impact 90 of 90 residents. Findings include: Employee records were reviewed on 3/31/25 at 9:30 a.m. and indicated the following: a. Housekeeper 2 (H 2), with a hire date of 9/9/24, lacked a job-specific orientation. b. QMA 3, with a hire date of 9/9/24, lacked a job-specific orientation. c. CNA 5, with a hire date of 9/9/24, lacked a job-specific orientation. During an interview on 3/31/25 at 3:05 p.m., the DON indicated the facility would look for specific orientation for H 2, QMA 3 and CNA 5. A current, 4/2022, facility policy titled, "General Orientation", indicated: "...Each new employee will be scheduled by the Department Head/Supervisor to receive orientation beginning the first day of employment which is to be completed no later than by the 30th day of employment..."	R 0123	All staff who were found to be in violation of the regulation have been assigned the required job-specific orientation. The Executive Director in- serviced all department managers on the General Orientation policy which includes the required job-specific orientation being completed within 30 days of employment. The Business Office Manager/ designee audited the employee files and identified those employees whose job specific orientation checklists have not been completed. Those employees have been assigned the checklists and will be completed prior to the compliance date. The Business Office Manager/ designee will audit employee files weekly x4 weeks and then monthly x6months. Variances will be corrected at the time of observation and results will be reviewed by the community's QAPI committee.	05/09/2025

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	03/31/2025

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
	No further information was provided by the facility prior to the survey exit.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure food was prepared and served under safe sanitary conditions regarding food handling and hand washing. This deficient practice had the potential to impact 90 of 90 residents who received their meals from the facility kitchen. Findings include: During a lunch service observation on 3/28/25 from 12:12 p.m. to 12:45 p.m., the following food handling and food services concerns were observed: Dietary Employee 8 (DE 8) was dipping food from the serving dish and placing food items on plates for meal service. With her gloved hands, she opened a bag containing buns. With the same gloves, she touched counter tops, dusted residue off counter tops, opened buns, placed puns on plates, touched the food contact surface of the plate, straightening a fritter on a bun, and arranged food on a plate. She repeated this process throughout the meal service. At 12:41 p.m., DE 8 removed her gloves and washed her hands for 10 seconds. She turned off the sink with her bare hands. The sink where DE 8 washed her hands was partially blocked by a steam table lid and a pan with condiments. The employee had access to about half of the sink. During an interview on 3/28/25 at 12:42 p.m., DE 8 indicated she should have washed her hands for	R 0273	All dietary staff was in-serviced on the Hand Hygiene Policy, with return demonstration, by the dietary manager/designee. The Dietary Manager/designee will monitor a meal service daily x30 days, weekly x4 weeks, then monthly x6months to ensure compliance. Variances will be corrected at the time of observations and results will be reviewed by the community's QAPI committee.	05/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/31/2025

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

20 seconds and turned off the sink with a dry paper towel.

At 12:38 p.m., Cook 6 left the dining and meal service area wearing a pair of gloves. He went down the hall to the kitchen area. At 12:41 p.m., Cook 6 returned to the dining and meal service area. He was pushing a 3-shelved rolling cart containing dishes and utensils. Upon entering the dining area, he began picking up clean plates with the gloves he had worn to push the cart. He made contact with the food contact portion of the plate.

During an interview on 3/28/25 at 12:43 p.m., Cook 6 indicated he was wearing the same gloves he had worn before leaving the dining and meal service room. He had not considered removing his gloves and washing he hands and applying new gloves after leaving the area and touching the handles of the cart.

A current, undated, facility policy titled "General Food Preparation Policy and Procedure," provided by the DON on 3/28/25 at 2:15 p.m., indicated: "...If gloves are used to handle ready-to-eat food, they shall be single-use gloves....shall be used for no other purpose and shall be discarded when damaged or soiled or when interruption occur in operations...."

A current, 3/2024, facility policy titled "Hand Hygiene," provided by the DON on 3/28/25 at 2:42 p.m., indicated: "...All personnel must wash their hands at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water....When coming on duty...Before or after eating or handling food...The use of gloves does not replace handwashing..."

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	03/31/2025

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
	This citation relates to Complaints IN00455754 and IN00455760.			
R 0299 Bldg. 00	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance Based on interview and record review, the facility failed to ensure pharmacy recommendations were communicated to the resident's physician for review and decision making for 1 of 3 residents reviewed for pharmacy services (Resident F). Findings include: Resident F's clinical record was reviewed on 3/28/25 at 2:10 p.m. Current diagnoses included Insomnia, hypertension, and macular degeneration. The resident had a current physician's order for Ambien/zolpidem 10 mg (a medication to treat insomnia) 1 tablet every night, dated 11/10/24. The resident had a 2/4/2025, "Pharmacy Recommendation to Prescriber" which indicated: Recommendation date: 1/28/25. Recommendation: Zolpidem 10 mg at bedtime is order for (resident F's name). Doses greater than 5 mg were not recommended in the elderly. Please consider changing the dose to zolpidem 5 mg every night as needed. The form contained an area for "Prescriber's Response" which was blank. The resident had a 12/3/24, "Pharmacy Recommendation to Prescriber" which indicated: Recommendation date: 11/29/24. Recommendation: Zolpidem 10 mg at bedtime is order for (resident F's name). Doses greater than 5	R 0299	The DON contacted Resident F's physician and received a new order based on the pharmacy recommendation. The DON/designee in-serviced all required nursing staff on the Pharmacy Services policy. The DON/designee will audit all pharmacy recommendations for signature and notification prior to the date of compliance of the regulation. DON/designee will audit all pharmacy recommendations weekly x4 weeks monthly x6 months. Variances will be corrected at the time of observation and results will be reviewed by the community's QAPI committee.	05/09/2025

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	03/31/2025

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 were not recommended in the elderly. Please consider changing the dose to zolpidem 5 mg every night as needed.
The form contained an area for "Prescriber's Response" which was blank.

The clinical record lacked documentation that the physician/prescriber had been notified of the pharmacy recommendation and had been given an opportunity to consider said recommendations.

During an interview on 3/31/25 at 2:00 p.m., the DON indicated the facility had a practice of faxing pharmacy recommendations to the resident's physician. The facility did not keep any record of when recommendations were faxed. The facility did not have a practice to contact physician's when no response was received form faxed pharmacy recommendation. The facility had no record of when Resident F's 2/4/25 and 12/3/24 recommendations were faxed to the residents physician nor what action was taken when no response was received.

A current, 9/2022, facility policy titled, "Pharmacy Services," provided by the DON on 3/31/25 at 3:18 p.m., indicated: "...The Director of Nursing or designee, will ensure that the medication review, recommendations and notification of the physician, if necessary, is documented...."

This citation relates to complaints IN00455445 and IN00455760.