

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>016063</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/02/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VITA OF GREENFIELD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1683 COMMUNITY WAY GREENFIELD, IN 46140</b>
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R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00462199.</p> <p>Complaint IN00462199 -- Residential deficiencies related to the allegations are cited at R0052 and R0090.</p> <p>Survey dates: July 1 and 2, 2025</p> <p>Facility number: 016063</p> <p>Residential Census: 54</p> <p>These Residential findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on July 7, 2025.</p>	R 000		
R 052	<p><b>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense</b></p> <p>(v) Residents have the right to be free from:</p> <ol style="list-style-type: none"> <li>(1) sexual abuse;</li> <li>(2) physical abuse;</li> <li>(3) mental abuse;</li> <li>(4) corporal punishment;</li> <li>(5) neglect; and</li> <li>(6) involuntary seclusion.</li> </ol> <p>This RULE is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident was free from neglect, when a resident with a diagnosis with dementia, who was displaying a recent change of condition, exited the secured memory care unit (MCU) of the facility without staff knowledge and was found outside of the facility by a visitor for 1 of 3 residents reviewed for elopement risk. (Resident</p>	R 052		

Indiana Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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R 052	<p>Continued From page 1</p> <p>B)</p> <p>Findings include:</p> <p>On 7-2-25 at 1:32 p.m., the Director of Nursing (DON) provided a copy of a facility reported incident (reportable). The reportable indicated Resident B had a "witnessed elopement" on 6-9-25 at 3:01 p.m.</p> <p>In a telephone interview with a family member of Resident B on 7-2-25 at 10:14 a.m., they indicated the facility had notified the family of Resident B getting outside of the secured MCU on 6-9-25, shortly after the occurrence. The family member indicated he had gotten out of the secured MCU once before. "This time, he followed some family out the entrance for the MCU. From my understanding, they are supposed to have somebody stationed there at the entrance to keep an eye on who is coming and going. Well, that day, that didn't happen. If that person had been at their station by the door, they would have seen [name of Resident B] heading out the door and been able to stop it."</p> <p>In an interview with the DON on 7-1-25 at 12:55 p.m., she indicated Resident B "did elope on 6-9-25 between noon and 1:00 p.m. I received a text notifying me he had gone out the door of the main entrance to the memory care unit. He followed a family out. From what I saw on the camera, it looked like he picked up his pace to get right behind them to get out of the building. Initially, that family didn't seem to really notice, but apparently they figured out something wasn't right when he started throwing rocks. No one was at the concierge desk at the entry at the time. That family let us know immediately what had happened. His behaviors had been escalating in</p>	R 052		

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R 052	<p>Continued From page 2</p> <p>the weeks before this happened. He also had an elopement attempt back in April." She indicated Resident B did have some increasing behaviors in the weeks prior to the elopement. Examples the DON provided of increasing behaviors included, but were not limited to, obtaining used personal care items for sexual satisfaction, entering other resident rooms and taking clothing and going to the exit doors and tearing off the door alarms.</p> <p>An observation of the facility's security footage (video) was conducted with the DON, who also provided a narrative of the soundless video, was conducted on 7-2-25 at 11:12 a.m. The DON indicated the timestamp of the video was correct. The video of Resident B exiting the secured memory care unit was timestamped as beginning on 6-9-25 at 2:09 p.m., of an interior view of the entrance/exit of the secured memory care unit. The DON indicated her previous report of the occurrence of between noon and 1:00 p.m., was incorrect. The observed video was as follows:</p> <ul style="list-style-type: none"> <li>-Two family members were observed to sign out at the desk near the secured memory care unit entrance. The female was observed to enter a code on the code pad and exit out the double doors. After the code was entered, both walked out the double doors at 2:10:19 p.m.</li> <li>-Resident B was observed to follow the male and female out the door at 2:10:23 p.m., prior to the door shutting. There appeared to be no indication or acknowledgement by the two persons of Resident B exiting behind them. The male and female turned to the right towards their vehicles.</li> <li>-After exiting the door, Resident B was observed to turn to the left of the double doors, bend down and picked up several small rocks from the</li> </ul>	R 052		

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R 052	<p>Continued From page 3</p> <p>landscaping and then to pull up plants or weeds for about two minutes. He was then observed to stand up and toss a rock/rocks towards a parked dark colored vehicle directly in front of him and the facility entrance, then, to walk back towards the sidewalk. The DON indicated he was heading east while walking on the parking lot area, not the sidewalk area.</p> <p>-The DON then switched to a different camera view, identified as the rear parking lot, an east view of the parking area, timestamped at 2:12:13 p.m., and identified as "another view" of Resident B. The video indicated once Resident B exited the building, he bent over to pick up rocks, stand up, toss several rock/rocks into parking lot.</p> <p>-At 2:11:54 p.m., Resident B was observed to toss/throw a rock towards the car as addressed previously.</p> <p>-At 2:12:13 p.m., he was observed to toss several rocks into the parking lot in a random pattern. The other resident's family members were observed at the far right end of this parking area, near the facility's van. It did not appear the male or female were looking towards Resident B at this time.</p> <p>-Between 2:12:13 p.m. and 2:13:07 p.m., Resident B was observed to walk towards north/northeast, away from the entrance, and in the opposite direction of the male and female.</p> <p>-At 2:13:50 p.m., the female was observed to re-enter the facility by utilizing the code pad. The DON indicated this was the time the female notified the staff of Resident B being outside of the secured memory care unit.</p> <p>-At 2:16:01 p.m., Staff 3 was observed to exit the facility and to walk towards the area in which Resident B was last viewed. The DON indicated this would have been to the north or northeast. Staff 3 was observed to be walking in the same direction Resident B had been observed and she</p>	R 052		

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R 052	<p>Continued From page 4</p> <p>can be seen using her cellular phone at this time. The DON indicated this was the approximate time she had received a text message from Staff 3 regarding Resident B being outside and prior to Staff 3 reaching Resident B. The DON indicated there was not a camera that was located to capture the location of Resident at that point or when Staff 3 was able to catch up to the resident.</p> <p>-Staff 3 and Resident B came back into view at 2:17:33 p.m., walking towards the memory care unit's entrance. He was observed to continue to toss rocks towards the pavement and was observed to pick up more rocks along the return route, as well as continuing to toss rocks in no particular manner or location.</p> <p>-At 2:18:34 p.m., Staff 4 was observed to exit through the double doors and join Staff 3 and Resident B.</p> <p>-At 2:18:45 p.m., Resident B was observed near the entrance, bending down to pick up more rocks and to pull at the green landscaping, tossing rocks intermittently and in haphazard manner.</p> <p>-At 2:20:42 p.m., Resident B and Staff 4 were observed to re-enter the facility.</p> <p>-A return to the interior video of the entry way to the memory care unit displayed Staff 3 returned into the building at 2:20:23 p.m., and Resident B and Staff 4 returned into the building at 2:20:50 p.m.</p> <p>In an interview on 7-2-25 at 1:50 p.m., with the Corporate Nurse, she indicated Resident B "did get out of the building by following a family member out the door. That family told us they could see him the entire time and they did come back in and let us know he was out in the parking lot. So, since he had eyes on him the entire time, we did not consider it an elopement since someone was aware of him the entire time." She</p>	R 052		

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R 052	<p>Continued From page 5</p> <p>indicated facility staff were with the resident within a few minutes of him following the other resident's family members outside.</p> <p>A review of the clinical record of Resident B was conducted on 7-1-25 at 10:02 a.m. It indicated he had diagnoses that included, but were not limited to, moderate dementia without behavioral disturbance. His most recent service plan, dated 4-19-25, indicated he required ongoing assistance with care "due to advanced dementia with speech, functional, and behavioral impairments." It indicated he required frequent supervision and redirection "due to wandering outside and/or off community premises." Interventions listed for this concern, included, but were not limited to, "The Care Team provides redirection when I am wandering or attempting to leave the building unassisted in order to keep me safe. Reduce resistance to redirection and reduction in exit seeking behavior...Provide interventions and a plan to reduce exit seeking during the day." It listed the staff responsible for these interventions as the Activities Coordinator, Administrator, Caregiver, Resident Care Coordinator/Director, Family, Med Tech and Nurse.</p> <p>An "Elopement Risk Assessment," dated 4-24-25, indicated Resident B was cognitively impaired with poor decision-making skills, ambulated independently, was unable to verbalize the importance of not leaving the facility without first notifying the staff, did not have a prior history of elopement and does wander, with a statement of, "resident enjoys walking alone and with other residents." This document failed to identify Resident B had exited or eloped from the secured memory unit on 4-17-25, when he opened an exit door and was found near that exit door by a staff</p>	R 052		

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R 052	<p>Continued From page 6</p> <p>member. Additionally, the document failed to identify any actual risk level for elopement. This document failed to identify whom had completed the assessment. This document did not identify whom completed the form.</p> <p>In an interview on 7-2-25 at 1:50 p.m., with the Corporate Nurse, she indicated she recalled addressing concerns with the elopement assessment tool used by facility during the April, 2025, complaint survey. She indicated she recalled mentioning the facility had plans at that time to update the elopement assessment tool due it did not have a legend to explain or define a resident's elopement risk level. She indicated the facility at that time was in the process of changing electronic health record (EHR) systems and the new system went live yesterday (7-1-25). She indicated the facility has a new elopement risk assessment form ready to input into the new EHR system as soon as possible.</p> <p>On 7-1-25 at 1:30 p.m., the Corporate Nurse provided a copy of an undated policy entitled, "Elopement Policy." This policy indicated, "The purpose of this policy is to establish guidelines for preventing, managing, and responding to elopement incidents involving residents...Residents in Assisted Living may be at risk for elopement due to cognitive or physical impairments. Vita is committed to identifying at-risk residents, implementing preventative measures, and ensuring an immediate and coordinating response to elopement incidents. Definitions: Elopement: The act of a resident leaving the premises unsupervised or unnoticed posing a risk to their safety. At-Risk Resident: A resident who has a cognitive, behavioral, or physical condition that increase [sic] the likelihood of elopement. All Residents will be assessed for</p>	R 052		

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R 052	<p>Continued From page 7</p> <p>elopement risk upon admission and during regular care plan reviews. The assessment includes: Cognitive impairments (e.g., dementia, Alzheimer's); Behavioral history (e.g., past elopement attempts); Physical ability to exit the premises unsupervised; Documentation of risk assessments and individualized care plans for at-risk residents will be maintained in the resident's record...Prevention Measures: Environmental Controls: Exit doors will be equipped with alarms, locks or keypads as allowed by state regulations. Security cameras will monitor entry and exit points...All visitors and contractors will be informed of the Community's elopement prevention measures and instructed not to allow residents to exit the premises unsupervised...Documentation: Complete an incident report detailing the event, actions taken, and outcomes. Update the resident's service plan to prevent recurrence. Reporting and Compliance: All elopement incidents regardless of outcome, must be reported to the Indiana State Department of Health in compliance with state reporting requirements..."</p> <p>This Residential tag relates to Complaint IN00462199.</p> <p>2.5-1.2(v)(5)</p>	R 052		
R 090	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency</p> <p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual</p>	R 090		

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R 090	<p>Continued From page 8</p> <p>occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for</p>	R 090		

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R 090	<p>Continued From page 9</p> <p>inspection to any member of the public upon request</p> <p>This RULE is not met as evidenced by: Based on interview and record review, the facility failed to ensure an unusual occurrence related to a resident of the secured memory care unit exiting the facility without staff knowledge was reported within 24 hours of becoming aware of the event for 1 of 3 residents reviewed for elopement risk. (Resident B)</p> <p>Findings include:</p> <p>On 7-2-25 at 1:32 p.m., the Director of Nursing (DON) provided a copy of a facility reported incident (reportable). The DON indicated a "screen shot," of the time and date the reportable was sent by the facility to the Indiana Department of Health's Long-Term Care Division was 6-14-25 at 3:31 p.m. The reportable indicated Resident B had a "witnessed elopement," on 6-9-25 at 3:01 p.m.</p> <p>In an interview with the Corporate Nurse on 7-2-25 at 1:50 p.m., she indicated she had filed the reportable regarding Resident B exiting the facility when he left the building by following another resident's family member out the door. She indicated the family had informed the facility they were able to see him the entire time and they did come back in and informed the facility he was out in the parking lot. So, since he had eyes on him the entire time, we did not consider it an elopement since someone was aware of him the entire time. The staff was outside with him within</p>	R 090		

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R 090	<p>Continued From page 10</p> <p>a few minutes of him following him outside. The reason the reportable was even filed was that there was some conversation back and forth as should we or shouldn't we report it to the state, so at the end of the week, we went ahead and reported it late.</p> <p>On 7-1-25 at 1:30 p.m., the Corporate Nurse provided a copy of an undated policy entitled, "Elopement Policy." This policy indicated, "The purpose of this policy is to establish guidelines for preventing, managing, and responding to elopement incidents involving residents...Residents in Assisted Living may be at risk for elopement due to cognitive or physical impairments. Vita is committed to identifying at-risk residents, implementing preventative measures, and ensuring an immediate and coordinating response to elopement incidents. Definitions: Elopement: The act of a resident leaving the premises unsupervised or unnoticed posing a risk to their safety. At-Risk Resident: A resident who has a cognitive, behavioral, or physical condition that increase [sic] the likelihood of elopement. All Residents will be assessed for elopement risk upon admission and during regular care plan reviews...Reporting and Compliance: All elopement incidents regardless of outcome, must be reported to the Indiana State Department of Health in compliance with state reporting requirements..."</p> <p>This Residential tag relates to Complaint IN00462199.</p> <p>2.5-1.3(g)(1)</p>	R 090		